MERIDIAN ADVANCED PSYCHIATRY

Acknowledgment of Receipt of Notice of Privacy Practices

A. I have received a copy of Meridian Advanced Psychiatry's Notice of Privacy Practices- **Initial**_____

B. I agree and understand that other patients will receive medical care during my visit and may overhear information regarding my care plan. **Initial** _____

C. I agree that a Registered Nurse, Medical Assistant, or Nursing /Medical Assistant Student may assist in my care. **Initial** _____

D. I consent to the MAP representative contacting me by telephone or leaving a message at the provided number. The MAP representative will identify with their first name and the practice's name, MAP. No specific information regarding my treatment will be discussed or left via voicemail. **Initial** _____

E. I consent to MAP representatives contacting me via Text Message at the number provided. Standard text rates may apply. The MAP representative will identify with their first name and the practice's name, MAP. No specific information regarding my treatment will be texted. **Initial** _____

_____ _____ _____

Patient/Guardian Print Name | Patient /Guardian Signature | Date

This Section is for Office Use Only

We attempted to obtain written knowledge of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- The individual refused to sign.
- Communication barriers prohibited obtaining the acknowledgment.
- An emergency prohibited obtaining the acknowledgment.
- Other (please specify): _____

_____ _____ _____

MAP Representative Print Name | MAP Representative Signature | Date

_____

Patients Account Code