Brent C. Sigler, M.D., P.C.
10099 RidgeGate Parkway, Suite 410
Lone Tree, CO 80124
(303)770-4040

Acknowledgment of Notice of Privacy Practices

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be use to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment for third-party payer.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

If I wish to receive a copy of Dr. Sigler's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information, I may request this information from the front desk. I understand that I have the right to a paper copy of this more complete notice if I so request.

_____ _____

Name of Patient (please print) **Date of Birth**

I hereby acknowledge that I received Brent C. Sigler, M.D. Notice of Privacy Practices.

_____ _____

Signature of patient or patient representative Date

Documentation of Good Faith Efforts
To obtain patient's acknowledgment that they received provider's Notice of Privacy Practices

(For use when acknowledgment cannot be obtained from the patient.)

The patient presented to the office on _____ [insert date] and was provided with a copy of Covered Entity's Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgment of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

☐ Patient refused to sign.
☐ Patient was unable to sign or initial because:
_____
☐ The patient had a medical emergency, and an attempt to obtain the acknowledgment will be made at the next available opportunity.
☐ Other reason (describe below):
_____

_____ _____

Signature of **Employee** Completing Form Date