B.I.S. Community Clinic

Serving Bedias, Iola, Singleton and Surrounding Communities

Effective date: **September 2017**

B.I.S. Community Clinic, LLC Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have been provided with a copy of the Practice's Notice of Privacy Practices.

Print Name _____

Patient (or Patient Representative*) _____ Signature Date

For Practice Use Only

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

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

*If Patient Representative is signing, legal documentation must be included designating authority to sign or receive information. This form must be maintained for 6 years.