**Cardiology Associates of Palm Beach, P.A.**

**1401 Forum Way**
**West Palm Beach, FL 33401**
**561-478-1104**
**Fax: 561-478-9505**

**5507 S. Congress Avenue**
**Atlantis, FL 33462**
**561-434-3070**
**Fax: 561-434-5643**

## ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received and had an opportunity to ask questions concerning the above named practice's Notice of Privacy Practices.

Print:_____
Patient's Name

Sign:_____ Date:_____
Patient or Patient's Representative

If signed by Representative, print name of Representative:_____

Relationship to Patient:_____

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## DOCUMENTATION OF GOOD FAITH EFFORTS RE: PATIENT ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

*To be filled out only if patient is unable or unwilling to sign this Acknowledgement of Privacy Practices.*

Patient Name:_____ Date:_____

On this date, the patient presented for treatment and was provided with a copy of the practice's Notice of Privacy Practices. Although a good faith effort was made to obtain a written acknowledgement of receipt of Notice of Privacy Practices, one was not obtained for the following reason:

_____ Patient refused to sign
_____ Patient was unable to sign or initial because:_____
_____ There was an emergency and the practice will attempt to obtain the acknowledgement on the next treatment date.
_____ Other:_____

Name and signature of employee completing this form:

Sign:_____