**Acknowledgement of Receipt of Notice of Privacy Practices**

**I acknowledge:**

A copy of Surgical Associates of Venice & Englewood’s Notice of Privacy Practices was given/offered to me. If I received healthcare services in an emergency treatment situation, I was given the Notice as soon as reasonably practical after the emergency treatment situation.

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Signature of Patient or Representative Date

**Staff Use Only**

If an acknowledgment is not obtained, please complete the information below:

Patient’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of attempt to obtain acknowledgment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason acknowledgment was not obtained:

* Patient/family member received notice but refused to sign acknowledgment
* Emergency treatment situation
* Patient was incapacitated and no family member was present
* Unable to communicate due to language barriers
* Other (as described below)

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Staff Signature Date