NORTHSIDE CHEROKEE SURGICAL ASSOCIATES
900 Towne Lake Parkway, Suite 412 • Woodstock, GA 30189
770-924-9656 • Fax 770-852-7574

Acknowledgement of Receipt of "Notice of Privacy Practices" for Protected Health Information

I acknowledge that I have received a copy of Northside Cherokee Surgical Associates "Notice of Privacy Practices" for protected health information on the date set forth below.

_____
Date of Receipt

Patient Information *(please print clearly):*

_____ _____
Last Name *First Name* *Middle Initial* *Date of Birth (Month/Day/Year)*

_____ _____
Print Name of Parent/Legal Guardian/Personal Representative *Relationship to Patient*

_____
Signature of Patient/Parent/Legal Guardian/Personal Representative

Release and Assignment: The information I have given is correct to the best of my knowledge. I understand that it will be held in the strictest confidence, and it is my responsibility to inform Northside Cherokee Surgical Associates of any changes in my address, phone number or insurance. I understand that I am financially responsible for any amounts not covered by my insurance. _____
Initials

For use by Northside Cherokee Surgical Associates Personnel Only
*(complete this section if patient acknowledgment is **not** received):*

An Acknowledgement of Receipt of Notice of Privacy Practices was not received because:

- ☐ Patient refused to sign Acknowledgment
- ☐ Unable to gain signed Acknowledgment due to communication/language or other barrier
- ☐ Patient was unable to sign Acknowledgement due to emergency treatment situation
- ☐ Other: *Please indicate reason* _____

Signature of Northside Cherokee Surgical Associates Representative _____

Date _____