AANE, LLC

Ashley Chin, Psy.D. & Alexander Chin, Psy.D.
2700 PGA Blvd, Suite 101, Palm Beach Gardens, FL 33410
Phone: 561-316-9761
Fax: 561-622-8040

Notice of Privacy Practices Acknowledgement

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 used 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 from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certification.

I have read, received, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this business has the right to change its Notice of Policy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do not agree then you are bound to abide by such a restriction.

Patient Name

_____

Responsible Party Name (if patient is a minor) _____

Relationship to Patient _____

Signature _____ **Date** _____

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Office Use Only

I attempted to obtain the client's signature acknowledgement on the Notice of Privacy Practice Acknowledgement, but was unable to do so as documents below:

Initials _____ **Date** _____
Reason _____
_____
_____