Advanced Medical Psychiatric Services Inc.
3409 Calloway Dr., Suite 601
Bakersfield, CA 93312
Phone: (661) 589-1200 Fax: (661) 589-7500
E-mail: RGAMPS@gmail.com

# PATIENT INFORMATION FORM

Name: _____ Today's Date: _____
First Last

Address: _____
Street City State Zip

Phone: Home: _____ Cell: _____ Work: _____

E-mail: _____

What is the best way and time to contact you? _____

Date of Birth: _____ Age: _____ Gender: _____ SSN: _____

Marital Status: _____ Occupation: _____

Responsible party (if applicable): _____ Phone: _____

Address: _____
Street City State Zip

Primary Care Physician: Name: _____ Phone: _____

Address: _____
Street City State Zip

Emergency Contacts:

Name: _____ Phone: _____

Name: _____ Phone: _____

Will you be requesting reimbursement from your insurance company? _____

*If yes, please fill out the insurance information form.

How did you hear about my services? _____

Signature_____ Date: _____

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INSURANCE INFORMATION

Patient Name:_____ Date of Birth: _____
First Last

Patient Address:_____
Street City State Zip

Patient Phone: Home:_____ Work:_____ Cell:_____

SS#_____ Gender: _____ Marital Status:_____

Policy Holder Name:_____ Date of Birth:_____
First Last

Relationship to Client (spouse, child, parent, other): _____

Policy Holder Address:_____
Street City State Zip

Policy Holder Phone: Home:_____ Work:_____ Cell:_____

Policy Holder Date of Birth:_____ Policy Holder SS#_____

Policy Holder Gender:_____ Policy Holder Marital Status:_____

Policy Holder's Employer: _____

Name of Insurance Company:_____

Type of Policy: (HMO, PPO, Indemnity, EAP, other): _____

Member ID #:_____ Group #:_____

Phone number for benefits verification:_____

Does your insurance company have mental health benefits? _____

Deductible Amount:_____ Copay:_____

Number of sessions covered by insurance company?_____
_____ Initials

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# Authorization to Release and/or Obtain Health Information

Patient Name:_____ Date of Birth:_____
First Last

*Check all that apply

__ I hereby authorize Dr. Goklaney to release my medical information_____.
Name of Individual or Facility

__ I hereby authorize Dr. Goklaney to obtain medical information from _____.
Name of Individual or Facility

Address of Individual or Facility:

_____
Street City State Zip

Telephone of Individual or Facility:_____ Fax:_____

**Information to be Released/Obtained: Check all that apply:**

| | | | | | |
|---|---|---|---|---|---|
| | History and Physical | | Laboratory Reports | | Immunizations/Vaccinations |
| | Progress Notes | | Radiology Reports | | Other Diagnostic Reports |
| | Consultations | | Outpatient Clinic Records | | Operative Reports |
| | Discharge Summary | | Emergency Medicine Report | | EKG Report |
| | Other: | | | | |

**Specific Authorizations: Check all that apply:**

___ I authorize the release of information pertaining to drug and alcohol abuse diagnosis or treatment.

___ I authorize the release of information pertaining to mental health diagnosis or treatment.

___ I authorize the release of HIV/AIDS testing information

___ I authorize the release of genetic testing information.

**Purpose of Release/Obtaining Medical Information: Check all that apply:**

___ Coordination of Care ___ Continuity of Care

___ Billing and payment ___ At request of client or client representative

___ Other: _____

**Effective Date of Authorization**:_____ **Duration of Authorization**:_____

Please Note: Dr. Goklaney, like many other health organizations, physicians, hospitals, and health plans, is required by state and federal law to keep your health information confidential. For full details of Dr. Goklaney's privacy policies, please refer to the Notice of Privacy Practices. If you do authorize disclosure of your protected health information to an individual or organization who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

**My Rights**

- I understand this authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for: 1) conducting research-related treatment, 2) to obtain information in connection with eligibility or enrollment in a health plan, 3) to determine an entity's obligation to pay a clam, or 4) to create health information to provide to a third party. Under no circumstances, however am I required to authorize the release of mental health records.

- I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Dr. Goklaney and/or the individual or facility listed above. I understand that the revocation will not apply to information that has already been released in response to this authorization.

- I am entitled to receive a copy of this Authorization.

_____**Date**:_____ **Signature of Client or Client's Legal Representative**

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# PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.
All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against the physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This
immunity shall supplement, not supplant, any other applicable statutory or common law.
Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.
The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05; however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: General Provisions: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance

with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services

_____

Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL
ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

_____ _____ _____ _____

Physician's or Authorized Representative's Signature Date Patient's or Patient Representative's Signature Date

_____ _____

Print or Stamp Name of Physician, Medical Group, or Association Name Print Patient's Name

_____

(If Representative, Print Name and Relationship to Patient)


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**TREATMENT CONSENT FORM**

Please read carefully, initial on each page, sign and date on the last page.

**MEDICATION**

Medications may be indicated when your mental symptoms are not responsive to psychotherapy alone. When a mental illness markedly impacts your ability to work, maintain interpersonal relationships, or properly care for your basic needs, medication may offer much needed relief. If it is agreed that medications are indicated, I will discuss with you all of the medication options that are available to treat your current condition. I will present information in language that you can understand. You will learn how the medication works, its dosage, and frequency, its expected benefits, possible side effects, drug interactions, and any withdrawal effects you may experience if you stop taking the medication abruptly. By the end of the discussion you will have all the information you need to make a rational decision as to which medication is right for you.

You may already be receiving psychotherapy from another therapist, and are referred to me for medication management. In this case I will make a strong effort to coordinate care with your therapist (with your consent, of course). I believe communication between mental health professionals is key to providing effective care.

Not everyone is a good candidate for medication therapy. Such therapy requires strict adherence to dosage, and frequency, close follow-up, and sometimes regular blood tests. Your ability to adhere to medication treatment will be taken into consideration in making the decision to start such therapy. Overall, I am a strong proponent of the bio-psycho-social model of medical treatment. Treatment that considers your biological status, genetics, your psychological development, and social issues together will yield the best chance for success in achieving your goals.

**FREQUENCY AND DURATION OF VISITS**

At your initial visit, we will decide together the structure of your treatment. If medications are prescribed, or changed, I prefer to conduct follow-up visits in one to two weeks. This is necessary to ensure proper administration, and minimize any side effects you may experience. If your symptoms improve, follow-up visits can be spaced out at monthly intervals. We may discuss an alternate treatment structure depending on your circumstances.

_____ Initials

**FEES**

For an initial evaluation for cash pay, my fee is **$185.00**. The fee for follow up of medication management visits is **$85.00**. Other miscellaneous services such as filling forms and telephone correspondence will be discussed at the time of the visit.

**CANCELLATIONS AND NO-SHOWS**

If you must cancel or reschedule an appointment, I require at least 24-hour notice (weekends not included). If your appointment is on a Monday, the cancellation must be made by the same hour on

the preceding Friday. Cancellations that occur with less than 24-hour notice or failure to show to an appointment **will be charged $35.00.**

**PAYMENTS**

I will expect payment at the beginning of each visit, unless we have agreed on other arrangements. Payment will be due at the time of the visit. If payment is 60 days past due, I reserve the right to utilize legal resources such as collection agencies or small claims court in order to obtain payment for my services.

**MEDICAL RECORDS**

I am required by law, to keep complete medical records. Most of my medical records will be electronic, encrypted, and under fingerprint security. Any written records including the initial consent forms, letters, outside medical records, will be kept locked. You are entitled to review your medical record at any time, unless I feel that by viewing your records, your emotional or physical well-being will be jeopardized. If you wish to view your records, I recommend that we review them together to minimize any confusion or misinterpretation of medical terms. Time spent collecting, printing, copying, and summarizing the medical record will be charged the appropriate fee (see above)

**CONFIDENTIALITY**

The security of your sensitive information is of utmost importance to me, and I am bound by law to protect your confidentiality. Any disclosure of your treatment to others will require your explicit written consent. As described above, basic information about your treatment may be disclosed to your insurance company for purposes of prior authorization if necessary.

_____ Initials

**There are exceptions to this confidentiality, where disclosure is mandatory. These include the following:**

-If there is a threat to the safety of others I will be required by law to take protective measures including reporting the threat to the potential victim, notifying police, and seeking hospitalization

- When there is a threat of harm to yourself, I am required to seek immediate hospitalization, and will likely seek the aid of family members or friends to ensure your safety.

- In situations where a dementing illness, epilepsy or other cognitive dysfunction prevent you from operating a motor vehicle in a safe manner, I will be required to report this to the DMV

- If a mental illness prevents you from providing for your own basic needs such as food, water, shelter, I will be required to disclose information to seek hospitalization.

**CONTACT INFORMATION**

My voice mail at 661-589-1200 is the best way to contact me outside the office. I do carry a cell phone with me at all times, and check my voicemail regularly. When you leave a message, please state your name clearly, your phone number(s) (even if you think I have it), reason for calling, and let me know when is the best time to contact you. I will make every effort to return your call the same day with the exception of holidays and weekends. Please allow up to 24 business-hours for me to return your call before calling again. If you or someone close to you is in immediate physical danger, please call 9-1-1, or proceed to Good Samaritan Hospital SW. I have privileges at Good Samaritan Hospital SW and you are able to walk in voluntary. The hospital is located at 5201 White lane, Bakersfield, CA 93309 and can be reached at 661-398-1800. If I am out of the country, I will provide you with the name and number of a colleague who you can contact in an emergency.

_____ Initials

**TREATMENT CONSENT**

By signing below, you certify that you have read and understand the terms stated in the Treatment Consent Form. You indicate that you understand the scope of my services, session structure, fees, cancellation/no-show policies, payment policy, insurance reimbursement, confidentiality, the nature of my practice, and my contact information, and that you agree to abide by the terms stated above during the course of our therapeutic relationship.

Client name (please print): _____ Date: _____

Client's signature: _____

Psychiatrist: Ravi Goklaney, M.D. Date: _____

Psychiatrist signature:_____

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**NOTICE OF PRIVACY PRACTICES**

PLEASE REVIEW IT CAREFULLY.

My Pledge to Safeguard Your Protected Health Information

This notice is intended to inform you of the ways in which I may use and disclose medical information about you. It describes your rights and my obligations regarding the use and disclosure of your protected health information.

Protected Health Information (PHI) refers to any information in your medical record that could potentially identify you. It includes information about your past, present or future health or condition, the provision of health care to you, or payment for health care. Some examples of PHI include, but are not limited to: name, address, date of birth, age, phone number, diagnosis, medical record, and billing records.

I am required by state and federal law to maintain the security and privacy of your PHI, and to clearly outline my privacy practices, my legal obligations, and your rights in this Notice of Privacy Practices. This notice has been in effect since April 14, 2003, and I must abide by the terms described therein while it remains in effect.

How I May Use and Disclose Your Protected Health Information

In general, I am permitted to use/disclose your PHI for the purposes of treatment, payment for services, and for my normal health care operations. Most other uses/disclosures of your PHI will require your explicit permission via a signed Authorization. Below I outline the potential uses/disclosures of your PHI that do and do not require your written authorization, as described in the HIPPA Privacy Rule. Not every use or disclosure is listed, but they will fall within one of the following categories.

1) Uses and/or Disclosures of PHI for Treatment, Payment, and Health Care Operations That Do Not Require Authorization

Treatment: I may use/disclose your health information to a physician or other health care provider providing treatment to you or for the management of healthcare related services. This includes but not limited to consultations and referrals between one or more providers. I may disclose medical information about you to other physicians, nurses, technicians, medical students and other healthcare personnel that are involved in your care. For example, an insurance company may contact a provider on your behalf to facilitate your access to mental health treatment.

Appointment Scheduling/Reminders: The Privacy Rule allows me to contact you by phone/voicemail to schedule appointments and to leave appointment reminders, unless you specifically request an alternate means of communication.

Payment: I may use/disclose your PHI in order to obtain payment for the services I provide. As an example, your health insurance company may need to determine your eligibility and the coverage you receive for mental health services. In such a case, I am permitted to disclose your PHI to your health insurer.

Health Care Operations: I may use/disclose your PHI for purposes of standard health care operations. For example, I may disclose your PHI to your medical health insurer for case management or care coordination purposes. In addition, your PHI may be used to comply with law and regulations, contractual obligations, patients' claims, grievances or lawsuits.

2) Uses/Disclosures of PHI that Require Authorization

You may permit me via written authorization to use your health information or disclose it to anyone for any purpose. You may revoke that authorization in writing at any time. Any use/disclosure that took place while the authorization was in effect will not be affected by your revocation. Other than the permitted uses/disclosures described in this Notice, I cannot and will not use/disclose your PHI unless you give me written authorization.

3) Uses/disclosures of PHI that Do Not Require Your Authorization or Consent

HIPPA Privacy Rule provides that I may use/disclose your PHI without your Authorization in several different circumstances outlined below.

As Required by Law: I may use/disclose your PHI when required to do so by federal or state law as listed below.

To Avert Serious Threat to Health or Safety: I may use/disclose your PHI when necessary to prevent or lessen a serious and imminent threat to your health and safety or the health and safety of the public or another person. Any disclosure would be to someone with the capacity to help stop or reduce the threat. For example, if you communicate an intent to harm an identifiable victim, I am required by law to communicate that information to the potential victim and to the police.

Abuse, Neglect, and Domestic Violence: I may disclose your PHI to appropriate authorities if I have a reasonable suspicion you are a possible victim of abuse, neglect, domestic violence or of other crimes.

Child Abuse: Whenever I, in my professional capacity, have knowledge of or observe a child I know or reasonably suspect has been the victim of child abuse or neglect, I must immediately report this to the police/sheriff's department, county probation department, child protective services, or county welfare department. If I have knowledge of or reasonable suspicion that a child has suffered

psychological suffering as a result of verbal abuse, or that his/her emotional well-being is endangered in any other way, I may report this to the authorities listed above.

Adult and Domestic Abuse: If I, in my professional capacity, have observed or have knowledge of an incident that reasonably appears to be physical abuse, abandonment, abduction, isolation, fiduciary abuse or neglect of an elder or dependent adult, or if I am told by an elder or dependent adult that he or she has experienced these things, or if I have a reasonable suspicion this has occurred, I must report the known or suspected abuse immediately to the local ombudsman or local law enforcement. I do not have to report such an incident told to me by an elder or dependent adult if (a) I am not aware of any independent evidence that corroborates the statement that the abuse has occurred, (b) the elder or dependent adult has been diagnosed with a mental illness or dementia, or is the subject of a court-ordered conservatorship because of a mental illness or dementia; and (c) in the exercise of clinical judgment, I reasonably believe that the abuse did not occur.

Military and Veterans: If you are or were a member of the armed forces, I may release medical information about you to military command authorities as authorized or required by law. We may also release medical information about foreign military personnel to the appropriate military authority as authorized or required by law.

Public Health Disclosures: I may disclose PHI about you for public health purposes. These purposes include the following:

- Preventing or controlling the spread of disease or injury;

- Public health surveillance or investigations;

- Reporting adverse events with respect to food, medications, dietary supplements or problems with products;

- Notifying persons of recalls, repairs or replacements of products they may be using;

- Notifying a person who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition;

- Reporting to an employer findings concerning a work-related illness or injury or workplace-related medical surveillance;

Health Oversight Activities: I may use/disclose your PHI to governmental, licensing, auditing, and accrediting agencies as authorized or required by law.

Judicial and Administrative Proceedings: I may disclose PHI to courts, attorneys and court employees in the course of conservatorship and certain other judicial or administrative proceedings.

Lawsuits and Other Legal Actions: In connection with lawsuits or other legal proceedings, I may disclose your PHI in response to a court or administrative order, or in response to a subpoena, discovery request, warrant, summons or other lawful process.

Law Enforcement: I may use/disclose your PHI for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person, or reporting crimes in emergencies, or reporting a death suspected to be the result of criminal conduct.

Coroners, Medical Examiners and Funeral Directors: In a majority of circumstances, I may disclose medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine cause of death. I may also disclose PHI of clients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities: As authorized or required by law, I may disclose your PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities.

Protective Services for the President and Others: As authorized or required by law, I may disclose your PHI to authorized federal officials so they may conduct special investigations or provide protection to the President, other authorized persons or foreign heads of state.

Inmates: If you are an inmate of a correctional institution or under the custody of law enforcement officials, I may disclose your PHI to the correctional institution as authorized or required by law.

4) Uses/Disclosures Requiring You to Have an Opportunity to Object:

I may disclose your PHI in the following circumstances if I inform you about the disclosure in advance and you do not object. I may use or disclose health information to notify or assist the notification of (including identifying or locating) a family member, your personal representative or another person responsible for our care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your PHI, I will provide you with an opportunity to object to such use/disclosure. However, in the event of your incapacity or emergency circumstances and you cannot be given an opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interests. I will disclose only health information that is directly relevant to the person's involvement in your healthcare. You must be informed and given an opportunity to object to further disclosure as soon as you are able to do so.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

Your medical record is my property. However, HIPAA Privacy Rule grants you the following individual rights regarding your PHI:

Right to Inspect and Copy: You have the right to inspect and/or obtain a copy of your PHI in my mental health and billing records used to make decisions about you for as long as the PHI is

maintained in the record. On your request I will locate and copy your health information for a fee of $1.00 per page, and postage if the copies are to be mailed. Under certain circumstances, I may deny your request to inspect/copy your medical record. In such cases you may have the denial reviewed by another professional, and I will comply with the outcome of the review.

Right to Request an Amendment or Addendum: If you feel that your PHI in the medical record is incorrect or incomplete, you may request that I amend the information or add an addendum to the PHI.

The request must be made in writing and must clearly explain your reasons for the request. You have this right as long as the PHI is maintained in the medical record. I may deny your request to amend information if (a) the information was not created by me, (b) it is not part of the PHI kept by me, (c) it is not part of the information which you would be permitted to inspect and/or copy, and (d) it is accurate and complete in the record.

Right to an Accounting of Disclosures: You have the right to receive a list of certain disclosures I have made of your PHI

Your request must be made in writing and state the time period (no longer than six previous years, and not including dates before April 14, 2003. You are entitled to one accounting within any 12-month period at no cost. Any additional requests in the same 12-month period you will be charged for the cost of compiling the accounting. You will be notified of the cost of the accounting before any costs are incurred so that you may choose to withdraw or modify your request.

Right to Request Restrictions: You have the right to request restrictions or limitation on certain uses and disclosures of PHI about you for treatment, payment or health care operations, as well as information disclosed to an individual in your care or the payment for your care, such as a family member or friend. I am not required to agree to a restriction you request. You do not have the right to limit the uses/disclosures that I am legally required or permitted to make according to the Privacy Rule. If I agree to the restriction/limitation, I will put the agreement in writing, and abide by it except in emergency situations.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations: You have the right to request and receive confidential communication of PHI by alternative means and at alternative locations. For example, if you do not want a family member to know you are receiving my services, you may request that I send your mailings to another address. You must make your request in writing, with specifics as to how and where you wish to be contacted. I will do my best to accommodate all reasonable requests.

Right to a Paper Copy of This Notice: You have the right to obtain a paper copy of this Notice of Privacy Practices from me upon request.

Changes to My Privacy Practices and This Notice:

I reserve the right to change my privacy practices and this notice at any time provided the changes are permitted by applicable law. Prior to any changes, I will change this Notice, and make the new Notice available to you upon request. The revised Notice will be effective for PHI I already have about you as well as any information I receive in the future.

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ACKNOWLEGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You have the right to refuse to sign this Acknowledgement*

I, _____, have received a copy of AMPS Notice of Privacy Practices.
Print name here

Signature:_____ Date:_____

FOR OFFICE USE ONLY

AMPS attempted to obtain acknowledgement of client's receipt of the Notice of Privacy Practices, however acknowledgement could not be obtained because

_____ Individual refused to sign

_____ An emergency situation prevented him from obtaining acknowledgement.

_____ Other (explain) _____

_____

_____

_____