ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
(Electronic Version)

PRIVACY POLICIES AND PROCEDURES

This Notice of Privacy Practices is made available to you via our website and/or at your request. Please fill out the document and return to:

Advanced Vein Therapy
161 E. Mallard Dr, Suite 120
Boise, ID 83702
FAX: (208) 947-0100

I, _____ have been offered a copy of
Name of Patient- Please Print

Advanced Vein Therapy's **"Notice of Privacy Practices"**. This Notice describes in detail how my Protected Health Information (PHI) may be used or disclosed by Advanced Vein Therapy according to HIPAA regulations and further describes my rights under HIPAA.

Please check one box below:

O I have been offered a copy of the Notice of Privacy Practice and acknowledge I have received a copy.
O I have been offered a copy of the Notice of Privacy Practice and am DECLINING to accept a copy.

Your signature below documents that you have been offered the Notice of Privacy Practices.

_____ _____
Signature of Patient Date

_____ _____
Printed Name of Authorized Representative Date

_____ _____
Signature of Authorized Representative Describe Authority to act on behalf of Patient.

O Patient or Authorized Representative refused to sign this Acknowledgement. _____
Printed Name of AVT Agent/Employee

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