Patient Acknowledgement of Receiving the Notice of Privacy Practices

I understand that as part of my health care, David J. Abrams, Psy.D., originates and maintains electronic records describing my health history, symptoms, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

A basis for planning my care and treatment.

A source of information for applying my diagnosis and other information to my bill.

A means by which third-party payors can verify that services billed were actually provided.

A tool for routine healthcare operations such as assessing quality and reviewing the competence of health-care professionals.

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices for Dr. David J. Abrams.

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Patient's Signature Date