North Pointe Psychiatry, PA
860 Hebron Pkwy, Suite 1101
Lewisville, TX 75057

Asad Islam, MD
Ph: 469-444-2244
Fax: 214-488-1200

PATIENT REGISTRATION

Date: _____ **Acct #:** _____

Patient Name: _____
Last **First** **Middle Initial**

SSN: _____ **Sex:** ☐ **M** ☐ **F** **Date of Birth:** _____

Home Address: _____

Cell Phone: _____ **Home Phone:** _____ **Email:** _____

Do you consent to communication via (check all that apply) ☐ **Cell Phone** ☐ **Home Phone** ☐ **Email?**

Do you consent to us leaving a message on the voicemail (check all that apply) ☐ **Cell Phone** ☐ **Home Phone?**

Do you consent to receiving appointment reminder text messages via your cell phone ☐ **Yes** ☐ **No?**

Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Separated** ☐ **Widowed**

Employed: ☐ **Yes** ☐ **No** **Student:** ☐ **Yes** ☐ **No**

Employer: _____ **Occupation:** _____

Address: _____ **Work Phone:** _____

~~~~~~

Referral Source: _____

~~~~~~

Emergency Contact: _____

Relationship to Patient: _____ **Phone Number:** _____

~~~~~~
~~~~~~

Spouse Name: _____ **Spouse DOB:** _____

Spouse's Employer: _____ **Sex:** ☐ **M** ☐ **F Spouse SSN:** _____

~~~~~~

Is the patient a minor? ☐ **Yes** ☐ **No** ****If yes, Parent/Guardian must fill information out below****

Mother's Name: _____ **Phone:** _____

Home Address: _____

Father's Name: _____ **Phone:** _____

Home Address: _____

~~~~~~

Patient Name (please print) **Date**

Signature of Patient/Parent/Guardian/Representative **Relationship to patient**

North Pointe Psychiatry, PA
Office Policies

Appointments:

- Our office hours are Monday through Thursday from 9:00 AM to 5:00 PM and Friday from 9:00 AM to 1 PM. Patient appointments are scheduled by calling us at **(469)444-2244** or emailing **northpointepsych@gmail.com** during regular office hours. It is recommended that next scheduled follow up appointments are made the same day being seen. We *cannot* guarantee same day or same week appointments if appointments are missed or not scheduled in appropriate time frame.

Financial Policy:

- Payment is due at the time of service by cash (exact change only) or credit card. We do not accept checks.
- Patients are due for their copayments and/or deductibles at the time that services are rendered for patients on Preferred Provider Plans (PPO's) or Health Maintenance Organizations (HMO's)
- If copay cannot be met at the time of service then the patient will not be able to be seen.
- If the patient has an outstanding balance it will need to be paid at the date of service. If the balance is less than $50.00, then the full amount will need to be paid at the time of service. If the balance is greater than $50.00, the patient will be obligated to pay 50% of that balance at each visit. If this cannot be met we are not obligated to provide services for that day.

Insurance:

- Your insurance policy is a contract between you and your insurance company; therefore, we cannot guarantee payment of your claims or accept responsibility of negotiating claims with insurance companies or other person(s).
- In the event of insurance denials, or non-covered services, the patient is responsible for all services rendered. If payment from your insurance carrier is not received within forty five (45) days, we will seek the full payment from the patient. Balance of services that are delayed or denied by your insurance company due to Coordination of Benefits information will become your responsibility after thirty (30) days.
- North Pointe Psychiatry, PA and its employees do not guarantee that payment will be authorized for medical services; therefore, this office is not responsible for any adverse payment decisions or misuse of information.
- Notifications of any change in your insurance status (i.e. new company, deductible, co- pay amounts) must be provided to the office twenty-four(24) to forty-eight (48) hours in advance of next visit, or payment in full will be required.
- You must obtain a copy of your insurance preferred drug formulary list, so that proper medications can be prescribed without a delay after being prescribed.

Miscellaneous Charges:

- Fees for medical records are $25.00 for the first 50 pages, anything over that will be a fee of $50.00 thereafter and may take up to 15 days to obtain. Walk-in/Emergency appointments are $25.00. Report preparation (Long letters that are more than half a page regarding to employers, schools, and disability forms or forms of any type that require to be filled out) are $50.00 based

on the time involved. These fees are not covered by insurance and are payable at the time of services rendered.

- If appointments are not cancelled twenty-four (24) hours in advance, our policy is to charge at the rate of $25.00 and is payable prior to the future visits. These will not be billed to your insurance company. Please help us serve you better by keeping your scheduled appointments or canceling in advance.
- There will be a $10.00 charge for some non-office visit refills of certain Schedule II Controlled Substances (ex. Adderall) when you are calling in for the refill. This payment must be obtained before sending out your prescription and this can be done via phone, email or in person.

Refill Request / Messages:

- All request for refills must be made forty-eight (48) hours in advance.
- We are not obligated to refill any controlled medications if appointments are missed and/ or not made accordingly.
- If any controlled medications are lost, or stolen we are not obligated to refill those until the next scheduled appointment.
- Any voicemails that are left after 3:00 PM will be returned the following business day.

Emergency Situations:

- Medications refills are only addressed during business office hours.
- If an emergency, call 911 or go directly to your nearest emergency room.

Thank you for understanding our office policy.Our goal is to make your visit with us pleasant and professional. If you have any questions, please feel free to ask our office staff for assistance. Thank you for choosing North Pointe Psychiatry for your care.

I have read and understood the office policies and I agree to be bound to its terms. I also understand and agree that such terms may be amended from time to time by the practice.

Patient Name (please print) **Date**

Signature of Patient/Parent/Guardian/Representative **Relationship to Patient**

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

Primary Care Physician
Doctor's Name: _____
Office Address: _____
Phone Number: _____ **Fax Number:** _____
Authorization to contact PCP (check one): ☐ **Yes** ☐ **No**

Therapist
Name: _____
Office Address: _____
Phone Number: _____ **Fax Number:** _____
Authorization to contact Therapist (check one): ☐ **Yes** ☐ **No**

Pain Management Doctor
Name: _____
Office Address: _____
Phone Number: _____ **Fax Number:** _____
Authorization to contact Pain Management Doctor (check one): ☐ **Yes** ☐ **No**

Other Provider
Name: _____
Office Address: _____
Phone Number: _____ **Fax Number:** _____
Authorization to contact Provider (check one): ☐ **Yes** ☐ **No**

***Authorization may be revoked at any time by notifying the office. Records are protected under state and federal law.**

Patient/Parent/Guardian Signature: _____

NORTH POINTE PSYCHIATRY, P.A.

Patient Registration and Consent for Treatment

This consent applies to a variety of patient situations. Due to practical limitations, alterations are not accepted. If you have any questions regarding this consent form, office management will be happy to assist you.

I. Consent for Treatment:

I am presenting myself to North Pointe Psychiatry, P.A. for evaluation, diagnosis and/or treatment of my medical condition. I give consent and authorize my physician(s) or his designees to perform and/or perform all exams, test, procedure and any other deemed necessary or advisable for the evaluation, diagnosis and treatment of my medical condition. This consent is valid for each visit I make to NORTH POINTE PSYCHIATRY, P.A., unless and until revoked by me in writing, I acknowledge that NORTH POINTE PSYCHIATRY, P.A. is committed to protecting the confidentiality of my medical record information in accordance with applicable laws and regulations. However, in order to provide treatment to me and to conduct billing and other health care operation activities, NORTH POINTE PSYCHIATRY, P.A. requires permission to disclose my medical records to certain individuals and entities. Therefore, I give consent and authorize NORTH POINTE PSYCHIATRY, P.A. to disclose any or all of my medical record information, including but not limited to treatment information, insurance and other financial information and information about communicable diseases such as human immunodeficiency virus (HIV), and acquired immunodeficiency syndrome (AIDS), alcohol and substance abuse, mental health diagnosis and treatment, and laboratory test results ("Medical Records"), to the following individuals and entities:

- Physicians and other healthcare personnel who are involved in providing or managing my healthcare. Disclosure to these individuals occurs through the sharing of paper medical records and through access to electronic systems
- My health insurance plan, Medicaid, Medicare, or any other person or entity that may be responsible for paying or processing payment for my medical treatment
- Employees, agents, representatives, volunteers or contractors of (989)780-5860 for the purpose of conducting health care activities including but not limited to administration, billing, compliance, quality assurance, risk management, credentialing and any other appropriate health care facility activities or operation
- Any person or entity to which I give written authorization to receive my Medical Records on a form provided by NORTH POINTE PSYCHIATRY, P.A. or such other forms acceptable to NORTH POINTE PSYCHIATRY, P.A.
- Any other person or entity that is required by law to have access to my Medical Records, I understand that the disclosure of my Medical Records may be necessary before my insurer will pay for the cost of my medical treatment. I agree not to hold NORTH POINTE PSYCHIATRY, P.A., its agents or employees liable for any damages as a result of disclosing my Medical Records in accordance with this consent

II. Assignment of Benefits/Causes of action:

In consideration of services or to be rendered to the patient, I assign my transfer to NORTH POINTE PSYCHIATRY, P.A. up to the amount of my total financial obligation to NORTH POINTE

PSYCHIATRY, P.A. all right, title and interest in benefits payable out of any third party action, or out of recovery under the uninsured motorist provisions or out of the medical payment provisions of any automobile insurance policy (ies), or out of any other insurance proceeds that I am entitled to pursue before the Crimes Victims Compensation Division of the Texas Industrial Accident Board in the event my treatment is necessitated by injuries received as the result of a violent crime, but in no event shall this be construed to be an obligation of NORTH POINTE PSYCHIATRY, P.A. I understand that this agreement in no way restricts me or my dependents' rights to pursue any such claim before the Crimes Victims Compensation Division of the Texas Industrial Accident Board.

III. Financial Responsibility:
In consideration of services rendered or to be rendered to the patient, I accept financial responsibility and agree to pay for any and all charges and expenses incurred or to be incurred. I further understand that payment is due upon request. Unless NORTH POINTE PSYCHIATRY, P.A. has a contract with my insurance carrier that states otherwise, I am responsible for my remaining balances after reasonable collection efforts have been pursued with my insurance company. If my account becomes delinquent and it is necessary for my account to be referred to attorneys or collection agencies, I will pay all charges that are my obligation, reasonable attorney's fees and other collection expenses. I have received a copy of the practice policies.

IV. Federal and State Programs:
If I am eligible for health care benefits under any federal or state program, including but not limited to Medicare or Medicaid, I certify that the information given by me in applying for payment under any such programs, including Title XVIII and XIX of the Social Security Act, is correct. I authorize any holder of medical or other information about me to the Social Security Administration or intermediary or carrier any information needed for any federal or state program related claims, I request that payment of authorized benefits be made to NORTH POINTE PSYCHIATRY, P.A. on my behalf. I understand that I am responsible for all applicable health insurance deductibles and coinsurance amounts under these programs.

V. Accidental Exposure of Health Care Workers:
I understand that Texas Law provides, and I give consent, that I may be tested for possible exposure to certain communicable disease, including but not limited to the human immunodeficiency virus (HIV), the virus associated with AIDS, hepatitis B and C, and syphilis. Such testing will be conducted pursuant to applicable laws and can include but is not limited to the following situations, a)if a health care worker is exposed to my blood or other bodily fluid.

VI. Practice Policies:
By signing the Patient Registration and Consent for Treatment form (consent), I acknowledge that I have been offered a copy of the practice policies of NORTH POINTE PSYCHIATRY, P.A.

VII. Effect of Consent:
By signings the Patient Registration and Consent for Treatment form (consent), I acknowledge that I have read and understood the information contained in this consent. I accept the terms of this Consent, either on behalf of myself as the patient, or on behalf of the patient as an authorized legal representative of this patient.

This Consent supersedes all prior consents or other authorizations forms signed by me pertaining to issues discussed herein. I acknowledge that signing the Consent is a condition of treatment by NORTH POINTE PSYCHIATRY, P.A. and alteration of any/or refusal to sign this form will result in denial of treatment, I understand that I may revoke this Consent at any time, except to the extent that NORTH POINTE PSYCHIATRY, P.A. has initiated actions based on the form. Any revocation of the Consent may result in termination of patient care in accordance with the state law.

If signing as the legal representative, I represent to NORTH POINTE PSYCHIATRY, P.A. that I am legal representative of the patient. Should my legal authority terminate, I agree to provide written notification to NORTH POINTE PSYCHIATRY, P.A.

Patient Name (please print) **Date**

Signature of Patient/Parent/Guardian/Representative **Relationship to Patient**

NORTH POINTE PSYCHIATRY, P.A.

Contract for Controlled Substance Prescriptions

Controlled substances medications (i.e., narcotics, tranquilizers and barbiturates) are very useful, but have a high potential for misuse and are, therefore, closely controlled by local, states and federal governments. They are intended to relieve pain, thus improving function and/or ability to work. Our physicians are dedicated to restoring functional use in an efficient and functional manner.

1. Please call us early in the day or week for refills or changes in medications, as we will not be able to accommodate your request after hours or on weekends. Should you need a prescription or refill other than during office hours, you may need to be seen in an emergency room and evaluated by the attending physician.

2. Refills of controlled substance medications:

- Will be made only during regular office hours, Monday through Thursday from 9AM to 5PM and Friday from 9AM to 1 PM, and either during a scheduled office visit or as determined by your physician. Refills will not be made at night, on weekends, or during holidays
- Will not be made for early refills if the medication runs out early, lost, stolen or misplaced
- Must be requested within 24 hours ahead of your refill time

3. You are responsible for the controlled substance medications prescribed to you, please be sure to keep track of when you need a refill.

4. It may be deemed necessary by your doctor that you see a medication-use or other specialist at any time while you are receiving controlled substance medications. Please understand that if you do not attend such an appointment, your medications may be discontinued or may not be refilled beyond a tapering dose to completion. Also understand that if the specialist feels that you are at risk for psychological dependence (addiction), your medications will no longer be refilled.

5. Driving a motor vehicle may not be allowed while taking controlled substance medications and it is your responsibility to comply with the laws of the state while taking the prescribed medications.

6. If you violate any of the above conditions, your prescription for controlled substance medications may be terminated immediately.

7. If you are involved in obtaining controlled substance medications from another individual, forging or altering a controlled substance prescription, or using non-prescribed illicit (illegal) drugs, your prescription for controlled substance medications will be terminated immediately and you may also be reported to all of your physicians, medical facilities and appropriate authorities. Please understand that these actions are grounds for the ending of your relationship with NORTH POINTE PSYCHIATRY, P.A.

Patient Name (please print) **Date of Birth**

Signature of Patient/Parent/Guardian/Representative **Date**

Witness Signature **Date**

NORTH POINTE PSYCHIATRY, P.A.

Consent for Treatment with Psychoactive Medications

It is my sole responsibility to ask questions and request more information if needed in regards to the nature of the disease and all of the medications that will be prescribed to me during my treatment at NORTH POINTE PSYCHIATRY, P.A. If I am not satisfied I can refuse to accept any treatment including medications without negative actions on the part of NORTH POINTE PSYCHIATRY, P.A. I am also aware that before leaving after each office visit I can ask questions in regards to the following:

- The nature of your mental and physical condition
- The expected beneficial effects on your condition as a result of treatment with the medication(s)
- The probable health and mental health consequences of not taking medications, including the occurrence, increase or recurrence of symptoms of mental illness
- The existence of generally accepted alternative forms of treatment, if any, that could reasonably be expected to achieve the same benefits as the medication(s) and why the physician rejects the alternative treatment
- A description of the proposed course of treatment with medication(s)
- The side effects of varying degrees of severity are at risk of all medications and the relevant side effects of the medication(s) being prescribed including: a)any side effects which are known to frequently occur in most individuals b)any side effects to which the individual may be predisposed c)the nature and possible occurrence of the potentially irreversible symptoms of tardive dyskinesia in some individuals taking neuroleptic medication in large doses and/or over long periods of time d)Metabolic side effects such as weight gain and hyperglycemia including development of diabetes e)the need to advise staff immediately if any of these side effects occur
- A review of the Patient's Rights under the Consent to Treatment with Psychoactive medication Rule (see MHRS 9-7.0).
- WOMEN OF CHILDBEARING YEARS ONLY: Risks of using these medications in pregnancy including drug interaction which would interfere with the effectiveness of my birth control pill in current/future use, and the necessity to use alternate birth control measures. If pregnant or breastfeeding, I agree to discuss with my obstetrician or pediatrician before starting the medication(s).
- It is my sole responsibility to receive a complete explanation of psychoactive medication(s) before starting by means of: oral explanation or printed material and I understand that I may withdraw this consent at any time, refuse to take certain medications and/or can request for alternative treatment

Patient Name (please print) **Date**

Signature of Patient/Parent/Guardian/Representative **Date**

NORTH POINTE PSYCHIATRY, P.A.

Notice of Privacy Practices

This Notice describes how protected health information about you may be used and disclosed and how you can get access to this information.

Please review it carefully, the privacy of your health information is important to us.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your protected health information (PHI). We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your PHI. This Notice takes effect immediately, and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by the applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all PHI that we maintain, including health information we we created or received before we make the changes. Before we make significant changes in our privacy practices, we will change this Notice and make the new Notice available upon request. We will post a copy of our current notice in our office. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of the Notice, please contact us using the information listed at the end of this Notice.

UNDERSTANDING OUR PROTECTED HEALTH INFORMATION (PHI)

Each time you visit our office a record is made of your visit and it consists of PHI that includes your symptoms, examination notes, test results, diagnosis, treatment and plan of care for you. This PHI, often referred to as your health or medical information, serves as a:

- Tool for planning your care, treatment and any follow-up care you may need
- Means of communication, among other healthcare professionals who contribute to your care
- Legal document describing the care you received
- Means by which you and/or a third party payer (ex. Insurance carriers) can verify that services billed were actually provided
- Source of information for federal and state public health officials charged with protecting the health of the nation
- Tool that can be used to assess and continually improve the care rendered and the medical treatment that you receive

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI)

We use and disclose health information about you for treatment, payment and healthcare operations.

Treatment: We may use your PHI to treat you or disclose your PHI to a physician or other healthcare provider fo which you are referred for treatment.

Payment: We may use and disclose your PHI to obtain payment for services we provide to you. This includes submitting billing and charge information to your insurance company or third party payer for reimbursement of the treatment services that we provided you.

Healthcare Operations: We may use and disclose your PHI in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities reviewing the competence or qualifications of healthcare professionals, evaluating practitioners or provider performance, conducting training programs, accreditation and certification, licensing or credentialing activities.

To Business Associates for Treatment, Payment or Healthcare Operations: We may use and disclose your PHI to our business associates in order to carry out treatment, payment or healthcare operations that the business associate performs on our behalf. For example, we may disclose your PHI to a company we hire to bill insurance companies on our behalf to help us obtain payment for the treatment we provided you.

Your Authorization: In addition to our use of your PHI for treatment, payment or healthcare operations, you may give us written authorization to use your PHI to disclose it to anyone for any purpose. If you give us authorization you may revoke it in writing at any time. Your revocation will not affect any use or disclosure performed by your authorization while it was in effect, unless you give us written authorization, we cannot use or discuss your PHI for any reason except those described in the Notice.

To Your Family and Friends: With your verbal authorization we can disclose your PHI to family members, friends or other person to the extent necessary to help with your healthcare or with payment of your healthcare.

Person Involved in Care: we may use or disclose PHI to notify, or assist in the notification of a family member (including, identifying and locating), your personal representative or another person responsible for your care, your locations, your general conditions or death. If you are present, then prior to use or disclosure of your PHI, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose PHI based on determination using our professional judgement disclosing only PHI that is directly relevant to the person's levelement in your healthcare. We will also use our professional judgement and experience with common practice to make reasonable inferences of your best interest allowing a person to pick up filled prescriptions, samples, medical supplies or other similar forms of health information.

Required by Law: We may use or disclose your PHI when we are required to do so by federal, state or local law. We disclose your PHI in response to a court or administrative order including court ordered subpoenas of discovery requests.

Health Oversight Activities: We may disclose your PHI to a health oversight agency for activities authorized by law such as audits, investigations, inspections and licensure.

Public Health Reporting Including Abuse or Neglect: We may disclose your PHI to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your PHI to the extent necessary to avert a serious threat to your health or safety of others.

National Security: We may disclose to military authorities the PHI of Armed Forces personnel under certain circumstances. We may disclose to authorized Federal officials health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose to

correctional institutions or law enforcement officials having custody of PHI of an inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your PHI to provide you with appointment reminders such as voicemail messages, postcards or letters.

Laboratory/Pathology/Culture Results: All patients are attempted to be notified of their results by telephone if there appears to be a concern. It is your responsibility to call our office for your results if we are unable to reach you.

PATIENT RIGHTS

Access: You have the right to impact and obtain a copy of your PHI, with limited exceptions. You must make a request in writing to obtain access to your PHI. You may obtain a form to request access by using the contact information listed at the end of this Notice. There is a charge for medical records. If your records are transferred to directly to another physician there is no fee charged.

Disclosure Accounting: You have the right to receive a list of instances in which we disclosed your PHI for purposes, other than treatment, payment, healthcare operations and certain other activities, for the past 6 years. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost- based fee for responding to those additional requests. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

Restrictions: You have the right to request that we place additional restrictions on our use and disclosure of your PHI. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement, except in emergency situations. You may obtain a form to request restricted disclosures by using the contact information listed at the end of this Notice.

Alternative/Confidential Communication: You have the right to request that we communicate with you about your PHI by alternative means or to an alternative location. For example, you may request that we contact you at a work phone number instead of your home phone number. You must make your request in writing. Your request must specify the alternative means or action and provide satisfactory explanation on how payments will be handled under the alternative means or location you request.

Amendments: You have the right to request that we may amend your health information. Your request must be in writing and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our website or by electronic email, you are entitled to receive this Notice in written format. Email is to be used for initial contact, generalized information on procedures or scheduling appointments. Email cannot substitute for a physician visit. Do not send urgent emails or requests for immediate medical attention. Please call our office if in need of immediate assistance (469)444-2244.

QUESTIONS OR COMPLAINTS

If you want more information about our privacy practices or have questions or concerns please contact us. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice

please contact our privacy officer at (469)444-2244. You may be asked to submit your complaint in writing so that our Privacy Officer can complete a thorough investigation.

CONTACT INFORMATION

North Pointe Psychiatry, PA
860 Hebron Parkway Suite 1101
Lewisville, Texas 75057

Phone: (469)444-2244
Email: northpointepsych@gmail.com

NORTH POINTE PSYCHIATRY, P.A.

Acknowledgement of Receipt of Notice of Privacy Practices

You have the right to refuse to sign this Acknowledgement

NORTH POINTE PSYCHIATRY, P.A. has provided you with a copy of its Notice of Privacy Practices. This Notice of Privacy Practices explains your privacy rights as a patient and includes a complete description of the uses/or disclosure of my protected health information (PHI). 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 the treatment
- Obtain payment for that treatment
- Conduct normal healthcare operations

The practice has explained to me that the Notice will be available to me in the future at my request and that I have a right to obtain a copy of the Notice prior to signing this consent. I have been encouraged to read the Notice carefully prior to my signing this consent.

My signature below indicates that I have been provided a copy of the Notice of Privacy Practices by NORTH POINTE PSYCHIATRY, P.A. The practice has given me the opportunity to ask any questions about this notice and all of my questions have been answered.

Patient Name (please print) **Date**

____

Signature of Patient/Parent/Guardian/Representative **Relationship to Patient**

____

~~~~~~

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained due to the following:

____Individual refused to sign
____Communication barriers prohibited obtaining the acknowledgement
____An emergency situation prohibited obtaining acknowledgement
____Other:____

____

Practice Representative Signature **Date**
~~~~~~