Form 850

ACHIEVE THERAPY RESPONSIBILITIES

We are required by law to maintain the privacy of your Protected Health Information, to comply with the privacy policies outlined in this notice, and to provide you this notice of privacy practices. Achieve Therapy is permitted by law to reserve the right to amend or modify our privacy policies, our practices, and this document. You may review or receive copies of your PHI by submitting a written request. Achieve Therapy requires that request to review your PHI, receive copies of your PHI, or request to restrict disclosures of your PHI, be submitted in writing. Forms to request information may be obtained from the Privacy Officer.

COMMENTS OR COMPLAINTS

You may submit a comment or complaint about our privacy practices by sending a letter describing your concerns to:

Privacy Officer
Achieve Therapy
1425 S Columbia Road Avenue
Grand Forks, ND 58201

_____	_____/_____/_____	_____
Patient's Name	Date of Birth (mm/dd/yyyy)	Email Address

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a written copy of the Achieve Therapy Notice of Privacy Practices. I also acknowledge that I have been allowed to ask questions concerning this notice and my rights under this notice. I understand that this form will be a part of my record until such time as I may choose to revoke this acknowledgement. If I am not the patient, I represent that I am authorized by law to act for and on the patient's behalf.

_____	_____
Date	Signature of Patient or Authorized Agent

TO BE COMPLETED BY ACHIEVE THERAPY IF ACKNOWLEDGEMENT IS NOT OBTAINED

Good faith efforts were made to obtain acknowledgement from the patient or patient's authorized agent. The good faith efforts made and the reason acknowledge could not be obtained, were:

- □ Patient (or authorized agent) refused to sign after being requested to do so
- □ Minor presented without parent or authorized agent. NPP, acknowledgment form, and self-addressed envelope sent home with patient.
- □ Other: (please describe)

_____	_____
Signature of Achieve Therapy Associate	Date