

Geriatrics Planning & Solutions, Inc.
Your “GPS” to navigate a clear path for your health.
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Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have been offered a copy of Geriatrics Planning & Solutions, Inc.’s (GPS) **Notice of Privacy Practices**, and that I read and understood it. I understand that:

- I have certain rights to privacy regarding my PHI.
- GPS can and will use my PHI for purposes of my treatment, payment, and health care operations.
- The Notice explains in more detail how GPS may use and share my PHI for other purposes.
- I have the rights regarding my PHI listed in the Notice.
- GPS has the right to change the Notice from time to time and I can obtain a current copy of the Notice by contacting Arun S. Rao, MD.

Acknowledgement of Receipt of Notice of Patient’s Rights

I hereby acknowledge that I have been offered a written copy of the “**Rights of Each Patient**” adopted by the New Jersey Department of Health for ambulatory care facilities and a written or verbal explanation of these rights.

I further acknowledge that I understand the explanation given to me about my rights.

Signature of Patient

Date

Print Name of Patient

Legal Representative’s Name & Authority (e.g., guardian, healthcare proxy)

FOR OFFICE USE ONLY:

Good Faith Effort to Obtain Acknowledgement Form

Name of Patient: _____

Date of Birth: _____

I attempted to obtain the patient's or the patient's representative's signature on the HIPAA Notice of Privacy Practices Acknowledgment Form, but was unable to do so as documented below:

Reason: _____

Name: _____

Date: _____

Signature: _____