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Diplomate: American Board of Psychiatry and Neurology  
Board Certified – Child, Adolescent and Adult Psychiatry

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DOCUMENTATION OF GOOD FAITH EFFORT &  
ACKNOWLEDGEMENT OF THE HIPPA PRIVACY NOTICE

Patient Name: \_\_\_\_\_ Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

The patient presented for treatment on this date and was provided with a copy of the practice's Notice of Privacy Practices. A good faith effort was made to obtain a written acknowledgement was not obtained because:

- Patient refused to sign.
- Patient was unable to sign or initial because:

\_\_\_\_\_  
\_\_\_\_\_

- There was a medical emergency. (The practice will attempt to obtain acknowledgement at the next available opportunity.)
- Other reason, as described below:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of Witness: \_\_\_\_\_