WILLIAM G. BUSH, M.D., P.L.L.C.
Obstetrics/ Gynecology/ Infertility
1020 River Oaks Drive ● Suite 410
Jackson, MS 39232
Phone: (601)664-0111 Fax: (601)932-1308

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

Acknowledgment of Notice of Privacy Practices

I hereby acknowledge that I received William G. Bush, M.D., P.L.L.C.'s Notice of Privacy Practices.

_____ _____
Signature of patient or patient representative **Date**

Documentation of Good Faith Efforts
To obtain patient's acknowledgment that they received provider's Notice of Privacy Practices

(For use when acknowledgment cannot be obtained from the patient.)

The patient presented to the office/hospital on _____ and was provided with a copy of Covered Entity's Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgment of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

☐ Patient refused to sign.

☐ Patient was unable to sign or initial because:
_____
_____

☐ The patient had a medical emergency, and an attempt to obtain the acknowledgment will be made at the next available opportunity.

☐ Other reason (describe below):
_____
_____

_____ _____
Signature of Employee Completing Form Date