METROPLEX PULMONARY &SLEEP CENTER, P.A
4833 Medical Center Drive, Suite 6B McKinney, Texas 75069
Phone: 972-838-1892 Fax: 972-838-1896 or 972-954-6030

PATIENT HISTORY FORM			
Name: (Please print)			
Date of birth		Age:	
Describe the current medical problem or reason for today's visit:			
Have you had any recent **CT Scans**, **x-rays** or **lab tests**, relating to this problem? Yes No			
If yes, when and where were those done?			
Who is your primary care physician?			
Who is your referring physician for today's visit?			
Have you ever been diagnosed with the following?			
asthma	heart attack	sleep apnea	thyroid disease
chronic bronchitis	stroke	kidney disease	high cholesterol
emphysema	hypertension	gastric ulcers	congestive heart
pneumonia	diabetes	hepatitis	tuberculosis
Past Surgical History (If you have a list we can make a copy):			
Other Hospitalizations:			
Are you allergic to any medications? Yes No			
If yes please write the name of the Medication(s			
Current Medications: Please list **all medications** you are currently taking. We can also make a copy of your medication list if you have it with you.			
Are you using: Oxygen		CPAP	Nebulizer
Do you smoke (current smoker)? Yes No		if yes- how many packs a day?	
Ex-smoker: Number of years smoked		how many packs per day?	
Do you consume alcohol on a regular basis?		Yes No	If yes-how much?
Do you have any history of family diseases?			
Have you ever had the flu vaccine? Yes No			
Have you ever had the pneumonia vaccine? Yes No			
Occupation:			
Are you married? Yes No	Do you have any children? Yes No		
Do you have pets at home? Yes No			
Have you been exposed to dust, fumes, or asbestos? Yes No			
Do you snore? Yes No			
Do you stop breathing at night? Yes No			
Do you have difficulty falling asleep? Yes No			
Do you have difficulty staying asleep? Yes No			
What time do you go to bed?	And wake up?		
Time you usually fall asleep?	Number of times you wake up at night?		
Signature of Patient:			Date:

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Do you sleep walk? Yes No Do you talk while sleeping? Yes No
Do you sweat at night? Yes No Do you have nightmares/abnormal dreams?
Do you feel tired in the morning? Yes No
Do you have difficulty staying awake during the daytime? Yes No
Do you have restless leg symptoms? Yes No Do your legs ache at night? Yes No
Do you feel muscle weakness while laughing or crying? Yes No
Do you have: Fevers chills Do you sweat at night?
Do you get short of breath? Yes No with exertion (exercise) Yes No
When did you first notice shortness of breath? Days Weeks Months Years
Has the shortness of breath gotten worse over time? Yes No
If so, has it gotten worse: slowly suddenly
If so, how much exertion does it take: (circle all that apply?)
a) walking slowly b) walking quickly c) climbing up a slope/ hill d) climbing stairs
Does anything else make you short of breath?
Do you wake up at night short of breath? Yes No
Do your feet swell? Yes No
Do you feel shortness of breath when you first lie down at night? Yes No
When lying down do you prop your head up to breath comfortably? Yes No
Do you wake up wheezing at night? Yes No
Do you cough? Yes No How long have you been coughing for?
Does anything cause you to cough or worsen it?
Is cough worse at certain times of the day?
Is cough worse at night? Does it wake you up at night?
Do you bring up sputum? Yes No
What color is your sputum: Circle one: clear, white, gray, yellow, and green
On average how much sputum do you cough up during a day?
Have you ever noticed blood in your sputum? Yes No
Do you have pain/discomfort in your chest? Yes No If so, what area of chest?
What type of pain: a) sharp b) dull c) stabbing d) constant e) intermittent
Does pain shift to another part of your body? Yes No
Is pain worse with exercise? Yes No
Is pain worse with deep breathing? Yes No
Do you wheeze? Yes No What makes you wheeze?
Have you ever been exposed to Tuberculosis? Yes No
Do you suffer from: headaches seizures passing out spells dizziness
Do you experience: nausea vomiting diarrhea reflux
Do you experience: arthritis muscle aches
Did you notice: weight loss weight Gain fatigue
Print Patient's Name:
Signature of Patient: Date:

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Patient Registration		
Name: (please print)		Date of birth:
Address:		State: Zip:
Email address:		
Cell phone #:	Home Phone #	Work Phone#
Marital status:	Spouse's name:	
SS#: Employer:		
Emergency contact name: (Please print)	Phone #	
Relation:		
Which is the best number to contact you?		
Can we leave a message on your voice mail? Yes	No	
You can request your medical records to be mailed to your house. We will send those to you by USPS Certified mail and with signature confirmation. However, you must send us a written and signed request if you wish to receive your medical records via email.		
Who do you authorize to talk to us on your behalf in your absence? Name: Relation:		
Your Pharmacy's name:		Phone number
Your oxygen and/or CPAP machine supplier's name:		Phone number
INSURANCE INFORMATION		
Primary Insurance Company:		
Name of insured:		
Group #:	ID #:	
Secondary/Supplemental Insurance:		
Name of Insured:		
Group #:	ID #	
Tertiary/Supplemental Insurance:		
Name of Insured:		
Group#:	ID #:	
ASSIGNMENT OF INSURANCE BENEFITS		
I request that payment of authorized insurance benefits be made on my behalf to Metroplex Pulmonary and Sleep Center for any services furnished by the provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration, and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown.		
Signature of Patient:		
Or Authorized Representative:		
Date:		

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____

Date of Birth: _____

Social Security Number: _____

I acknowledge that Metroplex Pulmonary and Sleep Center provided me with a written copy its Notice of Privacy Practices.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

_____ _____

Patient Signature Date

_____ _____

Personal Representative Signature (if applicable) Relationship to Patient

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Sleep and breathing disorders are extremely common in this country and affect daytime wakefulness to different degree in each person. Obviously, each person must use his or her best judgement to be safe during operating heavy machinery, behind the wheel or working at heights. Furthermore, you should also be aware that sleep medications may cause daytime drowsiness as well. Therefore, you should not expose yourself to others to avoid possible harm due to potential drowsiness.

For your protection we require that you have received this notice. Therefore, please sign below.

Signature of Patient: _____ Date: _____

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Patient is responsible for the services/provided charges if insurance does not cover.

It is necessary for our office to enact the following policies effective January of each year due to the increase in high deductibles, co-insurance portions, co-payments of insurance companies' pending claims and withholding payments. Please feel free to ask for clarification if necessary.

Your office visit, PFT Pulmonary Function (breathing) Test, sleep study take home device, Labs (orders sent out), CPAP, or CPAP Supplies and Spirometry might not be paid by your insurance.
I hereby give authorization to Dr. Shahrukh Kureishy/Dr. Ferzana Mir and their staff to provide medical treatment. I understand that no guarantees have been made with regards to treatment success, and that there may be complications associated with the condition or with its proposed treatment. By signing below you are agreeing to pay for these services yourself, even if those are determined by your insurance as not to be "medically necessary."

We ask for your insurance information when we schedule your first appointment, and we make every effort to verify your benefits for procedures that are common in our practice. While we do our best to verify that our doctors are contracted and in network with your insurance plan, it is ultimately your responsibility that this is the case. Based upon information provided to us by your insurance company we will expect payment according to the benefits quoted. Your copayment, co-insurance or deductible per your insurance company, and as indicated on most insurance cards will be collected before seeing the doctor. We will then file your office visit superbill with your insurance company. However, you will be responsible for your portion after your insurance pays, and as it indicates on your EOB. Also, we will not be held responsible if you or your accompanied person/s falls and injures in or outside our office. Any outstanding balance will be due and payable upon receipt of the statement.
Many insurance plans have a requirement that patients must provide additional information to them before they will pay your claim. When this is the case, your insurance company will inform us that they have "pended" your claim for additional information. If that happens, the full balance due on your visit becomes your responsibility. Once an insurance company "pends" a claim, there is nothing that our office can do to get the claim paid. It is completely your responsibility to contact your insurance company to provide them the needed information so your insurance company pays the claim within 30 days. Additionally, you must notify us at the time of service if your insurance plan, group, or policy number changes so we can file your claim precisely.

Visits that have been filed by us in a timely manner but denied by your insurance after 60 days will become your responsibility. Please remember that our office files to your insurance as a courtesy to you. It is important to remember that your insurance policy is a contract between you and the insurance company.

I also understand that failure to appear on scheduled follow up or new patient visit appointment may result in a delay in the diagnosis, and treatment of a potentially serious condition. We call in advance to remind an upcoming appointment, and/or reschedule if the appointment cannot be kept. However, we will not be held responsible for complications arising from missed appointments due to the patient's noncompliance.

We reserve the right to charge $35 for missed appointment and no show not given (24 hours' notice by the patient.) Returned checks for insufficient funds will be subjected to $35 fees as well. Payment is expected at the time of service.

Signature of Patient: _____

Patient's Printed Name: _____

Responsible person's name if patient is unable to sign: (please print) _____

Responsible Person's signature: _____

Relation with the patient: _____

Date: _____

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Shahrukh A. Kureishy M.D
Metroplex Pulmonary &
Sleep Center
4833 Medical Center Drive- 6B
McKinney, TX 75069

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

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Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

Last _____ First _____ Middle _____

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

_____

CITY _____ **STATE** _____ **ZIP** _____

PHONE (_____)_____ **ALT. PHONE** (_____)_____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____)_____ Fax (_____)_____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____)_____ Fax (_____)_____

REASON FOR DISCLOSURE
(Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ☐ **All health information**
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☐ Other_____

Your initials are required to release the following information:

_____Mental Health Records (excluding psychotherapy notes)
_____Drug, Alcohol, or Substance Abuse Records
_____Genetic Information (including Genetic Test Results)
_____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X_____ _____
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X_____ _____
Signature of Minor Individual **DATE**

Watermark Medical ARES Questionnaire

PRINT IN CAPITAL LETTERS – STAY WITHIN THE BOX

First Name		Middle Initial	Last Name	
Weight	Pounds	**Age**	Years	Gender: Male ○ Female ○
Height	Feet / Inches		**Neck Size**	Inches
Date of Birth	Month / Day / Year		**ID Number**	Optional

Tally ARES Risk Points

Neck Size
+2 Male ≥16.5
+2 Female≥15.0

Score

COMPLETELY FILL IN ONE CIRCLE FOR EACH QUESTION – ANSWER ALL QUESTIONS

Have you been diagnosed or treated for any of the following conditions?

High blood pressure	Yes ○	No ○	Stroke	Yes ○	No ○
Heart disease	Yes ○	No ○	Depression	Yes ○	No ○
Diabetes	Yes ○	No ○	Sleep apnea	Yes ○	No ○
Lung disease	Yes ○	No ○	Nasal oxygen use	Yes ○	No ○
Insomnia	Yes ○	No ○	Restless leg syndrome	Yes ○	No ○
Narcolepsy	Yes ○	No ○	Morning Headaches	Yes ○	No ○
Sleeping Medication	Yes ○	No ○	Pain Medication e.g., vicodin, oxycontin	Yes ○	No ○

Co-morbidities +1 for each Yes response

Score

Do not assign any points for these eight responses

Epworth Sleepiness Scale: How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to mark the most appropriate box for each situation. (M.W. Johns, Sleep 1991)

0 = would never doze **1 = slight chance of dozing**
2 = moderate chance of dozing **3 = high chance of dozing**

	0	1	2	3
Sitting and reading	○	○	○	○
Watching TV	○	○	○	○
Sitting, inactive, in a public place (theater, meeting, etc)	○	○	○	○
As a passenger in a car for an hour without a break	○	○	○	○
Lying down to rest in the afternoon when circumstances permit	○	○	○	○
Sitting and talking to someone	○	○	○	○
Sitting quietly after lunch without alcohol	○	○	○	○
In a car, while stopped for a few minutes in traffic	○	○	○	○

Epworth Score **TOTAL** the values from all 8 questions,
If 11 or less **Score = 0**
If 12 or more **Score = 2**

Score

Frequency **0 - 1 times/week** **1 - 2 times/week** **3 - 4 times/week** **5 - 7 times/week**

On average in the past month, how often have you snored or been told that you snored?
Never ○ Rarely ○ +1 Sometimes ○ +2 Frequently ○ +3 Almost always ○ +4

Do you wake up choking or gasping?
Never ○ Rarely ○ +1 Sometimes ○ +2 Frequently ○ +3 Almost always ○ +4

Have you been told that you stop breathing in your sleep or wake up choking or gasping?
Never ○ Rarely ○ +1 Sometimes ○ +2 Frequently ○ +3 Almost always ○ +4

Do you have problems keeping your legs still at night or need to move them to feel comfortable?
Never ○ Rarely ○ Sometimes ○ Frequently ○ Almost always ○

Assign points for each of the first three responses

Signature	Area Code / Phone Number	**Total all 6 boxes from above**	**Point Total**
		If point total = 4 or 5 (low risk), 6 to 10 (high) and 11 or more (very high risk)	

ALLERGY IMPACT QUESTIONNAIRE

PATIENTS NAME: _____ **D. O. B.** ____/____/____ **DATE OF SERVICE:** ____/____/____

OFFICE STAFF ONLY: ICD-9 CODES FOR PATIENT: _____ : _____ : _____ : _____ : _____

1. Do you think you suffer from Allergies? _____ Yes / _____ No

2. Are the symptoms all year around or seasonal? Year Long / Seasonal

3. How long do your symptoms last during an allergy flare up? Less than 7 days / More than 7 days

4. What time of the day are your symptoms the worst? Morning / Afternoon / Night / All day

5. Are the symptoms worse in the spring, fall or both? Spring / Fall / Both

6. Do you have any sinus drainage issues? _____ Yes / _____ No If Yes, When? AM / PM / All day

7. Do you ever have watery or itchy eyes? Always / Most Times / Sometimes / Never

8. Do you cough or sneeze on a regular basis? _____ Yes / No _____ If Yes, When? _____

9. Do you have regular Upper Respiratory Infections? _____ Yes / _____ No If Yes, < 3 or > 3 per year

10. Do you think you might be allergic to Animals? _____ Yes / _____ No

11. Have you been diagnosed with Asthma? _____ Yes / _____ No If Yes, When? _____

12. Do you have a family history of Asthma? _____ Yes / _____ No

13. Have you ever been hospitalized for asthma? _____ Yes / _____ No If Yes, when was the last time? _____

14. How long have you resided in your current State? _____ Years / _____ Months

15. How long have you lived in your current residence? _____ Years / _____ Months

16. Did you have allergies in your previous residence or State? _____ Yes / _____ No

17. Are you currently taking any allergy medications? _____ Yes / _____ No

If yes, please list all medications including any over the counter (OTC) medications as well.

_____, _____, _____, _____

18. Are you currently taking any blood thinner medications? _____ Yes / _____ No

If yes, please list: _____, _____, _____, _____

19. Are you currently taking a beta-blocker for a heart condition? _____ Yes / _____ No / _____ Unsure

20. Are you or could you be pregnant? _____ Yes / _____ No

HIPAA Notice of Privacy Practices

Metroplex Pulmonary and Sleep Center
4833 Medical Center Drive Suite 6B
McKinney, TX 75069
972-838-1892

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment:
We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment:
Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations:
We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, **authorization** or opportunity to object unless required by law. **You may revoke the authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information and by law we must comply when the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.