AMIGS, L.L.C.

Patient Acknowledgement of Notice of Privacy Practices

As Required by the Privacy Standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

I have received a copy of the Notice of Privacy Practices of AMIGS, L.L.C. on the date indicated below.

I understand that if any changes are made to this Notice of Privacy Practices, a revised copy of the Notice will be posted in the offices of AMIGS, L.L.C.

I also understand that if I wish to receive additional copies of this Notice of Privacy Practices in the future or if I have any questions with regard to this Notice of Privacy Practices, I may contact:

FREEDOM MITCHELL
OFFICE MANAGER
105 COLLIER ROAD, NE SUITE 1010
ATLANTA, GA 30309
(404) 355-4885 OR Toll Free (866) 355-8364
(404) 355-2210 FAX

_____
Signature of Patient

PRINT NAME: _____

DATE: _____

THIS SPACE TO BE USED BY PRACTICE ONLY.

DATE ACKNOWLEDGEMENT DENIED BY PATIENT: _____

REASON DENIED BY PATIENT: _____

NAME OF PERSON REVIEWING DENIAL: _____

DATE: _____