

Blue Sky Neurology/ Blue Sky Outpatient Neurology

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Name of Patient (please print)

Date of Birth

I hereby acknowledge that I received the Notice of Privacy Practices of Blue Sky Neurology, LLC.

**Patient Signature
(or patient representative)**

Date

DOCUMENTATION OF GOOD FAITH EFFORTS

To obtain patient's acknowledgement that they received the Notice of Privacy Practices of Blue Sky Neurology.

Patient refused to sign

Patient was unable to sign because: _____

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

Other reason (describe below): _____

Employee Witness

Date