DESERT SPRING
BEHAVIORAL HEALTH

Privacy and Acknowledgement Notice

Notice of Privacy Practices / Receipt and Acknowledgement of Notice

Patient/Client Name _____

Date of Birth _____

Social Security Number _____

I hereby acknowledge that I have received and/or have been given an opportunity to read a copy of Desert Spring Behavioral Health Notice of Privacy Practice and How Medical Information May Be Used and Disclosed. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Lisa Roper, APRN at 1 (435) 703-9647.

The section below on this page is to be signed at the office.

_____ _____
Signature of Patient/Client Date

_____ _____
Signature of Parent, Guardrian or Personal Representative* Date

If you are signing as a personal representative of an individual, please decribe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

Please submit this form **no less than 2 weeks prior** to your scheduled appointment. Insurance information will be used to check eligibility, deductible and any authorizations needed for your visit . All other information will be given to the provider We will contact you promptly with any issues or concerns.

Thank you