ACKNOWLEDGEMENT OF
RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Wichita Psychiatric Consultants' Notice of Privacy Practices with the effective date of April 14, 2003.

I give permission for WPC to leave a message on my answering machine or with a third person who answers my telephone concerning a scheduled appointment reminder. **Circle one: Yes No**

If yes: **Telephone Number to be called:** ______________________________

Alternate Number to be called: ______________________________

We often are contacted by patient's family members or friends and asked to report on the patient's condition, or to provide information concerning charges and payment for services provided. If you are present at the time a family member requests such information, we may ask you whether you want us to share information with your family member or friend. If you are not present at the time such a request is made by a family member (e.g., over the telephone), we will follow your prior instructions in determining whether we should share any information. If you have not provided any such instruction, we will contact you before providing any specific response to an inquiry from a family member or friend.

Concerning payment: I give permission for WPC to discuss insurance, billing and accounting issues

with ______________________________ ______________________________
(print name) (relationship)

Please check *only ONE* of the following:

______ Do **not** share information with family members except in emergency situations.

______ Share information with my spouse only, unless I specifically direct you not to share certain information with my spouse. My spouse's name is ______________________________

______Share information with the following family members or friends upon their request, unless I specifically direct you not to share certain information:

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________
Signature of Patient or Patient Representative Relationship to Patient

______________________________ ______________________________
Print Patient Name Date