V.I. UROLOGIC CENTER, Inc.

PATIENT ACKNOWLEDGEMENT OF DISCLOSURE INFORMATION

My signature below acknowledges the following:

- I have received a copy/am aware of the ***Patient Bill of Rights***: as required by law and have had an opportunity to receive assistance in understanding and exercising these rights.

- I have received a copy/am aware of this office's ***Notice of Privacy Practices***, including the ***Private Health Information(PHI)*** designated at the time of the visit.

- I have received information on/am aware of the ***Infection Control*** measures utilized by this organization***(in the Disclosure/Grievance Information).***

- I have received a copy/am aware of *the* ***Practice Disclosure (about our Practice, Including the Grievance process)***and am comfortable with that information. I also understand this practices position on ***Do NOT Resuscitate (DNR) and Living Wills*** and that this practice does not honor these directives.

Signature of Patient/Representative_____Date_____

Above signature was not obtained because:

◯ Patient is unable and unaccompanied by a representative. Patient left with all pertinent disclosures.

◯ Patient refused to sign.

◯ Patient refused forms.