Central Arizona Endoscopy, LLC
Patient Consent and Acknowledgement of Privacy Practices
For Use and/or Disclosure of Protected Health Information to Carry Out Treatment, Payment and Healthcare Operations

<Patient name>_____, hereby states that by signing this Consent, I agree and acknowledge the following:

1. Notice of Privacy Practices ("Privacy Notice") for Central Arizona Endoscopy, LLC (the "Center") has been provided to me prior to my signing this Consent. The Privacy Notice includes a description of the permissible uses and/or disclosures of my protected health information ("PHI") the Center. I understand that a copy of the Privacy Notice will be available to me in the future at my request. The Center has encouraged me to read the Privacy Notice carefully prior to my signing this Consent. The Center reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

2. I understand that, and consent to, the following appointment reminders that will be used by the Center:
    a. A postcard mailed to me at the address provided by me; and/or
    b. Telephoning my home and leaving a message on my answering machine.

3. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described in the Privacy Notice, then the Center will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____
Signature Patient or Legal Representative Date

_____ _____
Signature Witness Date

FOR USE BY THE CENTER ONLY

Inability to Obtain Acknowledgement

To be completed only if no signature is obtained. If it is not possible to obtain the patient's acknowledgement, describe the good faith efforts made to obtain the patient's acknowledgement, and the reasons why the acknowledgement was not obtained:

_____
_____
_____
_____

Signature of Center representative:_____

Printed Name of Center representative:_____

Date:_____