Bloom Behavioral Solutions, Inc.
9141 Cypress Green Drive, Suite #2
Jacksonville, FL 32256
(904) 647-1849

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that the information can and will be used to:

- Conduct, plan and continue the treatment and follow-up among any provider with Bloom Behavioral Solutions, Inc. that may be involved in the direct or indirect treatment of my child.
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments clinician certifications

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the users and disclosures of my health information. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, that you are bound to abide by such restrictions.

Patient Name: ____

Relationship to Patient: ____

Signature: ____ Date: ________________________

Office Use Only:

Name of office staff as witness: ________________________________ **Time Entered:** __________________

Title/Position: ____

Signature of office staff as witness: ______________________________ **Date Entered:** __________________