



9655 Maroon Circle
Englewood, CO 80112
(800) 495-6670
(800) 495-6695 (FAX)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

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 this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received Zynex Medical, Inc.’s Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that Zynex Medical, Inc. has the right to change its Notice of Privacy Practices from time to time and that I may contact Zynex Medical, Inc. at any time at **ATTN: Privacy Official, 9655 Maroon Circle, Englewood, CO 80112** to obtain a current copy of the Notice of Privacy Practices.

Patient / Personal Representative Signature: _____

Relationship of Personal Representative: _____

Date: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- _____ Patient refused to sign
- _____ Communication barriers prohibited obtaining the acknowledgement
- _____ An emergency situation prevented us from obtaining acknowledgement
- _____ Other