NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT OF RECEIPT

I hereby acknowledge that I was provided with a copy of Advanced Practice Nursing Specialists' Notice of Privacy Practices prior to being seen as a patient at APNS, and I agree to all stipulations of the APNS Notice of Privacy Practices therein.

_____ _____
Signature Date

_____
Print Name

If completed by a patient's representative or guardian:

_____ _____
Signature Date

_____
Print Name

_____
Relationship to Patient

For Office Use Only

Complete this section if this form is not signed and dated by the patient or the patient's representative or guardian.

I have made a good faith effort to obtain a written acknowledgement of receipt of APNS Notice of Privacy Practices, but was unable to for the following reason:

- ☐ Patient refused to sign
- ☐ Representative or guardian refused to sign
- ☐ Patient unable to sign
- ☐ Other _____

Employee Signature: _____ Date: _____

Print Name: _____

Updated June 2026

Advanced Practice
Nursing Specialists, LLC
2851 N Tenaya Way Suite 101
Las Vegas, NV 89128

Tel: 702-586-1600
Fax: 702-586-1688
info@apnslv.com
www.apnslv.com