Acknowledgement of Review
Of Notice of Privacy Practices

I have been informed of this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____

Name of Patient **Date**

_____

Signature of Patient or Personal Representative

_____I authorize this office to share information with the following, concerning my medical treatment:_____
_____I authorize this office to leave a message on my answering machine regarding appointments for me concerning my medical treatment.

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Acknowledgement of Review
Of Financial Policy

I have received a copy of this office's Financial Policy. Once I have signed this acknowledgement, I agree to all the terms and conditions contained therein and the agreement will be in full force and effect.

_____

Patient's Name **DOB**

_____

Responsible Party (if not the patient)

_____

Signature **Date**
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