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ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____
Patient Name (please print) Date

_____ _____
Parent or Authorized Representative (if applicable) I give permission to the above named to have access to my file.

_____
Signature

SIGNATURE ON FILE

- ☐ I authorize use of this form on all my insurance submissions.
- ☐ I authorize release of pertinent information to all my insurance companies.
- ☐ I understand that I am ultimately responsible for my bill.
- ☐ I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.
- ☐ I authorize payment direct to my doctor.
- ☐ I permit a copy of this authorization to be used in place of the original.

Print Name: _____ SS#: _____

Signature: _____ Date: _____