FROST FAMILY MEDICINE

ACKNOWLEDGEMENT OF RECEIPT
Notice of Privacy Practices

Your name and signature on this form indicates that you have received a copy of Frost Family Medicine's ***Notice of Privacy Practices*** on the date and time indicated below.

If you have any questions regarding the information contained in the ***Notice of Privacy Practices,*** please contact us at 843-815-5211.

Printed Name: _____

Signature: _____

Relationship to Patient: _____

Date Received:_____Time Received: _____

FOR FACILITY USE ONLY

We attempted to obtain written acknowledgement of patient's receipt of our ***Joint Notice of Privacy Practices***, but acknowledgement could not be obtained from the patient for the following reason:

- ☐ Individual Refused to Sign
- ☐ Emergency Situation Prevented Signature
- ☐ Patient Requested Above Individual Sign on His/Her Behalf
- ☐ Other (please specify) _____

Registration Representative Signature: _____ Date: _____

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