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PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name: ________________________________Birth date: __________

Signature __________________________________ Date ______________

SIGNATURE ON FILE

- □ I agree to allow use of this form on all my insurance correspondences.
- □ I authorize release of information to all my Insurance Companies.
- □ I understand that I am responsible for payment of my bill.
- □ I authorize my doctor to assist me in obtaining payment from my Insurance Companies.
- □ I authorize payment directly to my doctor.
- □ I permit a copy of this authorization to be used in place of the original.

Name (please print) __________________________

Signature __________________________________ Date ______________

Telephone: ___________________________________ (home)

___________________________________ (cell)