

Do we have permission to leave a detailed message on your answering machine/voicemail, with a family member or a legal representative regarding appointments, billing, or other matters regarding your treatment?

Yes_____ No_____ Other_____ (please specify)

May we call you at work? Yes_____ No_____

ACKNOWLEDGEMENT

I acknowledge that I have received the Notice of Privacy Practices.

Print Patient's Name

Patient or Personal Representative
Signature

Date

If personal Representative's signature appears above, please describe
Personal Representative's relationship to the patient:
