Notice of Privacy Practices
Acknowledgement of Receipt of Notice

Patient Name:_____

Date of Birth:_____

By signing below, I acknowledge that I have received and have been given an opportunity to read Central Coast Family Acupuncture's Notice of Privacy Practices.

_____

Signature of Patient of Parent/Legal Guardian/Legal Responsible Party

_____

Date

To Be Completed by Central Coast Family Acupuncture

Central Coast Family Acupuncture sought, but was unable to obtain, acknowledgement for the patient or patient's responsible party for the following reason:

- ☐ Patient/Legally Responsible Party refuses to acknowledge receipt
- ☐ Other:_____
  _____

_____

Signature of Central Coast Family Acupuncture Representative Date

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