



Please Print: First Name M.I. Last Name

Acknowledgment of Receipt of Patient Bill of Rights

By my signature below, I acknowledge that I have received the Patient Bill of Right.

Signature

Date

Relationship to patient (if not signed by patient)

Staff initials

Acknowledgment of Receipt of Notice of Privacy Practice

By my signature below, I acknowledge that I have received the Notice of Privacy Practices.

Signature

Date

Relationship to patient (if not signed by patient)

Staff initials