

Evergreen Integrative Medicine L.L.P.

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Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signed: _____ Date: _____

Print name: _____ Telephone: _____

If not signed by the patient, please indicate:

Relationship

- parent or guardian of minor patient
- guardian or conservator of an incompetent patient
- beneficiary or personal representative of deceased patient

Name of Patient: _____

For Office Use Only

Date received:	Processed by:
Practice Follow-up <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Practice Follow-up:

Complete the following only if the patient refuses to sign the Acknowledgment:

Efforts to obtain: _____

Reasons for refusal: _____
