SURGICAL ARTS, PC

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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

____ _______________
Name of Patient or Personal Representative **Date**
(Please Print)

____ _______________
Signature of Patient or Personal Representative **Date**

____
Relationship of Personal Representative to Patient

If patient or personal representative is unable or refuses to sign the form, please document below:

☐ Patient or personal representative is unable to sign.

Reason: ____

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☐ Patient or personal representative refuses to sign.

Reason:

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