

# Patient Acknowledgement of Receipt

[ ]  Hours of Operation

[ ]  Notice of Privacy Practices

[ ]  Patient Responsibilities and Code of Conduct

[ ]  Patient Rights

[ ]  Sliding Fee Discount Notice

[ ]  Patient Centered Medical Home (PCMH) Notice

I acknowledge that I have received the following information. Should I need another copy of any of these documents I can request one at any time.

|  |  |
| --- | --- |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Signature | Date |
|  |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Printed Name | Date of Birth |
|  |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  Self |  |
| Relationship  |  |