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Office: 561. 756 93 43
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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse To Sign This Acknowledgement****

I, _____, have received a copy of the office’s Notice of Privacy Practices.
(Print Name of Patient / or Parent/Guardian)

(Patient Name)

(Date)

(Signature of Patient/or Parent/Guardian)

May we leave messages about your appointment on voicemail or with a family member on your behalf?
Yes _____ No _____

For Office Use Only

We have attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barrier prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

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