Acknowledgement of Receipt of Notice

ACI Hearing & Balance Center, Inc.

103 Saint Thomas St.
Lafayette, LA 70506

Kimberly Allred

337-235-6601

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

Signed: ______________________________ Date: ________ Print Name:________________________

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: ____

Yes No (circle one) I would like to receive a copy of any *amended* Notice of Privacy Practices by e-mail at: ______________________________.

Where can we contact you? Please check all that may apply:

__Work phone: _______________

__Leave a detailed message

__Leave only our name and number

__Home phone: ______________

__Leave a detailed message

__Leave only our name and number

__Cell phone: ________________

__Leave a detailed message

__Leave only our name and number

__Other phone: _______________

__Leave a detailed message

__Leave only our name and number

Please list, in detail, any and all friends or family members who are authorized to discuss your personal health information.

Name:	*Date of Birth:*	*Relation to you:*
__________________________	_________________	_________
__________________________	_________________	_________

For Office Use Only:

- Signed form received by: _________________________
- Acknowledgment refused:

Efforts to obtain: ____

Reasons for refusal: ____