**Always Best Care Medical Center, PA**

Acknowledgement of Receipt of Notice of Privacy Practices

\*\*You May Refuse to Sign This Acknowledgement\*\*

With my signature, I confirm, that I have received a copy of this office’s Notice of Privacy Practices

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patients Name (Please Print)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Guarantor / Parent

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient / Parent / Guarantor

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

**For office use only**

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

* Individual / Parent / Guarantor refused to sign
* Communication barriers prohibited obtaining the acknowledgment
* An emergency situation prevented us from obtaining acknowledgment
* Other ( Please Specify )

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