

Surgical Associates of North Texas
8865 Synergy Dr.
Suite 100
McKinney, TX 75070

Acknowledgement of Receipt of Privacy Notice

I have been given an opportunity to review a copy of Surgical Associates of North Texas Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand a copy of these Privacy Policies is kept in the lobby at all times for my review. I may request a copy of these policies at any time. I understand the contents of this Notice, and I request the following restriction(s) concerning the use of my personal medical information:

Further, I permit a copy of the authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

Signed: _____

Date: _____

If not signed by the patient, please indicate relationship (e.g., spouse)

Relationship: _____

Witnesses by: _____

Internal Use Only:

If the patient or patient's representative refused to sign acknowledgement of receipt of notice, please document the date and time the notice was present to the patient and sign below.

Presented on (date/time): _____

By (name/title): _____

Patient Paperwork: A fee of \$25.00 is required for all completed paperwork (work, disability, life insurance, etc.) and \$25.00 for FMLA forms. This fee will be charged and due prior to the release of the completed paperwork.

Initials: _____