Name:
DOB:
Chart:
Age:
Date:

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

PATIENT NAME _____ **DATE OF BIRTH** _____

I, _____, have received, or have had the opportunity to receive, the Notice of Privacy Practices from Waterbury Orthopaedic Associates, P.C.

In addition, I agree that Waterbury Orthopaedic Associates, may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

X _____ _____
Patient (or personal representative) signature Date

X _____
Relationship to patient if personal representative

****

TO BE COMPLETED IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGEMENT FROM PATIENT

On _____ I attempted to obtain a written acknowledgement of receipt of the Notice of Privacy Practices, but was unable to do so.

- o Patient declined to sign this Written Acknowledgement
- o Patient did not understand the request to sign the Written Acknowledgement
- o Other: _____

X _____
Staff member name and title