Advanced Neurosurgery

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Federal Law requires that we seek your acknowledgement of receipt of the Notice of Privacy Practices. Please sign below.

I acknowledge that I have received this Notice of Privacy Practices from Advanced Neurosurgery with an effective date of April 14, 2003, and that I understand that if I have any questions regarding this Notice, I may contact the Privacy Officer.

PATIENT NAME (please print)

PATIENT SIGNATURE DATE

PARENT/GUARDIAN'S NAME (please print)

PARENT/GUARDIAN'S SIGNATURE DATE

ACKNOWLEDGEMENT OF RECEIPT OF FINANCIAL/OFFICE POLICIES

PATIENT NAME (please print)

PATIENT SIGNATURE DATE

PARENT/GUARDIAN'S NAME (please print)

PARENT/GUARDIAN'S SIGNATURE DATE

FOR OFFICE USE ONLY

Signed Acknowledgement of Receipt received on (Date)

Received by

Patient Refused or Failed to Acknowledge Receipt on (Date)

Office Personnel