

Pacific Handworks

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PATIENT INFORMATION PRACTICES

I acknowledge receipt of a copy of the Notice of Patient Information Practices of Pacific Handworks:

Patient or Personal Representative Signature

Date

Please include the names of persons with whom we are allowed to discuss your billing information and/or condition:

Name

Relationship

Name

Relationship

Name

Relationship

I authorize Pacific Handworks, Inc. to discuss my billing information and/or condition with the above named person(s).

Patient or Personal Representative Signature

Date

May we leave a detailed message on your answering device if we are unable to reach you?

YES:

NO:

[All patients are required to complete and sign this form]