BEE CAVES Medical

LAKEWAY Medical

Acknowledgement of Notice of Privacy Practices

Patient Name: _____

I hereby acknowledge that I have received a copy of Bee Caves Medical / Lakeway Medical's Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgment if I so choose.

_____ _____

Signature of Patient or Legal Representative Date

Relationship to Patient (if applicable)

_____Parent or guardian of un-emancipated minor

_____ _____Court appointed guardian

Printed Name of Patient's Representative (if applicable) _____Executor or administrator of decedent's estate

_____Power of Attorney

FOR OFFICE USE ONLY

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

_____ Patient / Representative refused to sign

_____ Emergency situation prevented us from obtaining acknowledgment at this time.

(An attempt to obtain acknowledgment will be made at a later date).

_____ Communication barriers prohibited obtaining acknowledgment (Explain)

_____

_____

_____

_____ Other (Specify)

_____

_____