**Patient Acknowledgement of Receipt of the Notice of the Privacy Practices**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By signing this form, I am acknowledging that I have the right to receive a copy of the Notice of Privacy Practices of Hart and Arndt Family Health.

I have the right to review the Notice of Privacy Practices prior to signing this form. If I do not sign this form, Hart and Arndt Family Health may decline to provide treatment to me.

Hart and Arndt Family Health reserves the right to revise its Notice of Policy Practices at any time. A copy of such revisions is available upon written request.

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Signature of Patient or Legal Guardian Print Name of Legal Guardian

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_Today’s Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_