ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

Schneider Orofacial Myology, Inc.
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#7 N. Knoll Road Suite 6
Mill Valley, Ca. 94920

Section A: The Patient

Name: _____

Address: _____

Telephone: _____

Chart #: _____ Social Security # _____

Section B: Acknowledgement of Receipt of Privacy Practices Notice

I, _____, acknowledge that I have received a Notice of Privacy Practice from the above named practice.

Signature: _____ Date: _____

If a personal representative signs this authorization on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

Section C: Good Faith Effort to Obtain Acknowledge of Receipt

Describe your good faith effort to obtain the individual's signature on the form

_____

_____

Describe the reason why the individual would not sign this form:

_____

_____

Section D: Signature

I attest that the above information is correct.

Signature: _____ Date: _____

Print Name: _____ Title: _____

(Include this acknowledgement of receipt in the individual's records)