Meridian Audiology, LLC
Acknowledgement of Receipt of Notice of Privacy Practices

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information.

Our Office Policies contains important information regarding payment, insurance, collections, cancellations, returns, refunds and other important information.

By signing this form, I acknowledge that I have received a copy of this office's Notice of Privacy Practices, and Office Policies. You may refuse to sign this acknowledgment, if you wish.

Patient Name / Relationship: ____

Print your Name: ____

Signature: ____

Date: ________________________

For Office Use Only

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy Policies from this patient but it could not be obtained because:

___ The Patient refused to sign ___ We were not able to communicate with the Patient

___ Due to an emergency situation it was not possible to obtain a signature

Other (please provide details): ____
____
____

Employee Signature: _____________________________ Date: ______________