BERGER AUDIOLOGY
Your First Choice In Hearing Healthcare

Berger Audiology LLC

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Acknowledgment of Receipt of Notice

I hereby acknowledge that I am entitled to a copy of the medical practices notice of Privacy Practices.

○ Yes ○ No **I WISH TO RECEIVE A COPY OF NOTICE OF PRIVACY PRACTICES.**

Signed _____ Date _____

Name: Sample Patient **Telephone :**

If not signed by the patient indicate relationship

◉ Parent or guardian if patient is a minor
○ Guardian or conservator of an incompetent patient
○ Beneficiary or personal representative of deceased patient

Name of Patient (if different than above) _____

For office use only:
Signed and received by: _____

Date Acknowledgment refused: _____

Efforts to obtain:

Reasons for refusal: