ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Date of Birth:_____

Address: _____City, State, Zip code:_____

Phone Number: _____

I acknowledge that I received a copy of Adaptive Audiology Solutions PC's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, the website and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

- This Notice informs me how Adaptive Audiology Solutions PC will use my health information for the purposes of my treatment and/or payment for my treatment.
- This Notice explains in more detail how Adaptive Audiology Solutions PC may use and share my health information for other than treatment, payment, and health care operations.
- Adaptive Audiology Solutions PC will also use and share my health information as required/permitted by law.

_____ _____

Printed name of patient or personal representative Date

_____ _____

Signature of patient or personal representative Date

Permission to send you information:

By initialing this section and signing below, I authorize Adaptive Audiology Solutions to send me educational and/or marketing information on the products and services offered by Adaptive Audiology Solutions. No remuneration is involved in this communication. I understand that I may revoke this authorization, in writing, at any time.

_____ _____

Printed name of patient or personal representative Date

_____ _____

Signature of patient or personal representative Date