

PATIENT ACKNOWLEDGEMENT

I hereby acknowledge that I have received, reviewed and been given an opportunity to discuss a copy of this Privacy Notice.

I authorize the sharing of information necessary for insurance claims, and authorize payment directly to the provider office.

I also authorize the use of my/my child's images for promotional and educational purposes.

Please check this box if you would like to waive your right to a copy of the Privacy Notice

Please Print Patient Name:

Date:

Signature of Patient or Responsible Party/Legal Guardian:

Print name of Responsible Party/Legal Guardian: