Soundview Orthopaedics, LLP

Acknowledgement of Review / Receipt of Notice of Privacy Practices

Patient Name: ____ **Patient ID #:** _______________________

I hereby acknowledge that I have received or reviewed a copy of Soundview Orthopaedic Associates, LLP Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

____
Signature of Patient or Legal Representative

____
Printed Name of Patient's Representative (*if applicable*)

____
Date

Relationship to Patient (*if applicable*)
- ☐ Parent or guardian of unemancipated minor
- ☐ Court appointed guardian
- ☐ Executor or administrator of decedent's estate
- ☐ Power of Attorney

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FOR OFFICE USE ONLY

Form Policy

There will be a $15.00 fee for any form that requires to be filled out by the physician for disability/insurance purposes. The charge for AFLAC forms is $25.00.

Thank you.