52 Harrison St 2nd Floor Johnson City, New York 13790

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ________________________ (please print patient name), hereby agree that I have received a copy of the Neuro Medical Care Associates, PLLC Notice of Privacy Practices.

____________________________________ ______________________

Patient's Signature Date

If person signing form other than patient:

____________________________________ ______________________

Signature of Personal Representative Date

____

Relationship to Patient

Phone 607-729-1521 Fax 607-729-7320 www.neuromedical.org
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