PATIENT ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

Date: _____

I, the undersigned acknowledge that I have received the following disclosures from the practice.

- Facility Information (Public Knowledge)
- Patient Bill of Rights
- Complaint Resolution Policy
- Billing Information (please go to www.drborcich.net for further information)
  Billing Source: MD Billing Solutions
- Facility Ownership Disclosure
  (please go to www.drborcich.net for further information)
- Information on Pain Assessment (to be discussed with provider)
- Physician(s) Qualification
  (please go to www.drborcich.net for further information)
- Privacy Practices for Protected Health Information

_____
Signature of Patient or Representative

Patient's Name (Printed): _____

Name of Personal Representative: _____
(Printed) (If Applicable)

Relationship to Patient: _____
(If Applicable)