ACKNOWLEDGEMENT OF RECEIPT AND REQUESTED RESTRICTIONS.

By signing below, you acknowledge that you have received the *Notice of Privacy Practices, Notice of Separate Practices* and *No Show/Late Cancellation Policy* prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

Patient Name: _____
(Please Print Name)

Patient Date of Birth: _____

SIGNATURES:

Patient/Legal Representative: _____ Date:_____

If Legal Representative, relationship to Patient: _____