

**Bee Caves Medical**

**Acknowledgement of Receipt of Notice of Privacy Practices**

Patient Name: \_\_\_\_\_

Patient ID #: \_\_\_\_\_

I hereby acknowledge that I have received a copy of Bee Caves Medical's 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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient's Representative (if applicable)

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

**FOR OFFICE USE ONLY**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices on the following date \_\_\_\_\_, but acknowledgment could not be obtained because:

- Patient / representative refused to sign
- Emergency situation prevented us from obtaining acknowledgement at this time.  
(An attempt to obtain acknowledgement will be made at a later date.)
- Communication barriers prohibited obtaining acknowledgement (Explain)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- Other (Specify)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_