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Acknowledgement and Acceptance Form
Signature Page

I acknowledge having read and reviewed the HIPAA Notice of Privacy Practices form.

Patient Name: _____ *Date:* _____

Signature: _____

Patient Name: _____ *Date:* _____

Signature: _____

I have read, reviewed and agree to the Office Practices Form.

Patient Name: _____ *Date:* _____

Signature: _____

Patient Name: _____ *Date:* _____

Signature: _____