

**ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES**

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I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

By checking the lines below I authorize being contacted for practice reminders
by:
Mail _____ ;
Email _____ ; at email address _____
Telephone numbers _____ ;
Voice mail _____ ;

Patient Name (please print) _____ Date: _____

Name of Parent, Guardian or Patient's legal representative _____

Signature of Patient, Parent, Guardian or Patient's legal representative

**THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND
MAINTAINED FOR SIX YEARS.**

List below the names and relationship of people to whom you authorize the Practice to release PHI.
