

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

- I have received a copy of Tri-City Audiology's Notice of Privacy Practices.
- I would like to receive postcard reminders of annual appointments.
- I do not wish to receive postcard reminders of annual appointments.

Please Sign Your Name: _____

Date: _____

You have the right to refuse to sign this document.

- I have received a copy of this office's Notice of Privacy Practices, but elect not to sign this receipt.
(Print your name only)

Please Print Your Name: _____

Date: _____

OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, however, acknowledgement could not be obtained because:

- Patient refused to sign.
- Communication barriers prohibited obtaining the acknowledgement.
- An emergency situation prevented us from obtaining the acknowledgement.
- Other (specify)

"Thank you for choosing Tri-City Audiology. We are proud to be your hearing healthcare professionals."



**Tri-City
Audiology**

MESA

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CHANDLER

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(480) 899-0076

TEMPE

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(480) 831-6159