

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**BETSY McCARLEY BILLYS M.D.
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I hereby acknowledge that I received a copy of this Medical Practices Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area and that I will be offered a copy of any amended notice of privacy practices at each appointment.

SIGNED: _____ DATE _____

PRINT NAME _____ TELEPHONE: _____

If not signed by the patient, please indicate relationship:

_____ parent or guardian of minor patient

_____ guardian or conservator of an incompetent patient

NAME AND ADDRESS OF PATIENT _____