LOS PALOS GASTROENTEROLOGY SPECIALISTS INC.
BUSINESS OFFICE
658 E ROMIE LANE, SALINAS, CA 93901
831-424-8888 PHONE 831-424-8889 FAX

I hereby acknowledge that I received a copy of this medical practice's 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.

Signature: _____ Date: _____

Printed Name: _____ Date: _____

If not signed by the patient, please indicate:

Relationship

- Parent or guardian of minor patient
- Guardian or Conservator of an incompetent patient

Beneficiary or Personal Representative of deceased patient

Name of Patient: _____

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INABILITY TO OBTAIN ACKNOWLEDGEMENT

This section is to be completed only if no signature is obtained because it is not possible to obtain the individual's acknowledgement. Describe the good faith efforts made to obtain the individual's acknowledgement and the reasons why the acknowledgement was not obtained.

Circle one.

- Patient unconscious or incoherent
- Patient heavily medicated
- Patient sent directly to hospital
- Parent/Legal guardian not available
- Other: _____
- Patient refused to sign receipt. Was Notice Given? YES _____ NO _____

Signature: _____ Date: _____
Staff / Employee