

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of Naturopathic Health Notice of Privacy Practices.

Patient or legally authorized individual signature Date

Printed Name if signed on behalf of the patient Relationship to patient

Acknowledgement of Payment

I hereby state that I understand that full payment for services and merchandise is due at the time that they are received. I also understand that the practice does not accept any form of insurance and that I as the client am responsible for the full amount billed.

Patient or legally authorized individual signature Date

Printed Name if signed on behalf of the patient Relationship to patient

Revisions (if any):
