Visalia Women's Specialty Medical Group, Inc.

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Acknowledgement of Receipt of Notice of Privacy Practices

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 of guardian minor patient

( ) guardian or conservator of an incompetent patient

( ) beneficiary or personal representative of deceased patient

Name of Patient: ______________________________________

Acceptance of Financial Responsibility

Patient Name: ___________________________________

History Number: _________________________________

I agree to be financially responsible for services rendered to me. I understand that my physician does not agree to accept MediCal coverage for these services.

Patient Signature _________________________________ Date ___________________________