

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Acknowledgement of Receipt of Notice  
of Privacy Practices and Financial Policy

You acknowledge that you were offered a copy of Coastal Dermatology and Skin Care Center of Alabama Notice of Privacy Practices and Financial Policy. If you would like to receive a paper copy at any time in the future, you can call (251) 378-0200.

Print Name of Patient: \_\_\_\_\_ Patient's Date of Birth: \_\_\_\_\_

Patient or Representative Signature: \_\_\_\_\_

Relationship of Representative: \_\_\_\_\_

Individual was unable to sign due to the following reason:

- Admitted directly to treatment area
- Left AMA or without being seen
- Unresponsive
- Not competent
- Refused to sign

Signature of facility representative: \_\_\_\_\_ Date: \_\_\_\_\_