Acknowledgment of Privacy Notice

I acknowledge that I have been given access to the Notice of Privacy Practices of Craig G. Burkhart, MD Inc. and I may request a copy at any time.

_____ _____

Printed Name of Patient Date

_____

Printed Name of Patient Representative

_____

Signature of Patient or Patient Representative

_____

Relation to Patient

I acknowledge that I have been given the office's Financial Policy Information and I agree to the terms.

Craig G. Burkhart, M.D. Inc.
5600 Monroe St. B106
Sylvania, OH 43560

***Please provide our office with any special instructions you may have:

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