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.

X_____ Date _____
Printed Name of Patient Representative

X_____
Signature

X_____
Relationship to Patient

You are ultimately responsible for all payment obligations arising out of your treatment or care and guarantee payment for these services You are responsible for nonnetwork, deductibles, co-payments, coinsurance amount or any other patient responsibility indicated by your insurance carrier or services that are not otherwise covered by supplemental insurance. I acknowledge that these are the office's Financial Policy and I agree to the terms.

X_____

Patient Signature or Guardian requesting services

Craig G. Burkhart, MD, Inc.
5600 Monroe Street, Building 106B
Sylvania, OH 43560