ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of Blue Ridge Orthopaedics and Sports Medicine, P.A. Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law.

I understand that I have the right to request restrictions concerning the use of my information. I request the following restrictions:

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With whom may we discuss your treatment:

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With whom may we discuss your payment:

____

________________________________ ____________________
Patient /Legal Guardian Signature **Date**

FEE COLLECTION POLICY

I have been given a copy of the Blue Ridge Orthopaedics and Sports Medicine, P.A. Fee Collection Policy. I have read and understand the payment policies stated in the Fee Collection Policy. I understand that if I do not keep my account current I will be subject to the process outlined for delinquent accounts.

______________________________ ____________________
Patient/Legal Guardian Signature **Date**