Robert L Jones, MD, FACS
1401 Avocado Ave, Ste 505
Newport Beach, CA 92660

Acknowledgment of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have been offered a copy of this medical practice's 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 an amended Notice of Privacy Practices.

Signed: ____ Date: ____________

Print Name: ______________________________ Phone: (____) ______________

If not signed by patient, please indicate relationship: ❑ parent or guardian of minor patient, ❑ guardian or conservator of an incompetent patient, or ❑ beneficiary or personal representative of deceased patient.

Name of Patient: ____

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Signed Consent for Practice to Send Reminder Notices by Mail

Notice comes in form of a postcard which displays doctor's name and the name of the practice as well as the patient's name and address.

Signed: ____ Date: ____________

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Patient refuses to sign this Acknowledgement

Reason: ____

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