

CAPITOL UROLOGY, INC.

**NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT FORM**

Name: _____

Date: _____

CHECK AND SIGN OPTION ONE OR OPTION TWO BELOW, PLEASE.

OPTION ONE:

_____ I have received a copy of Capital Urology, Inc. (the "Practice")'s Notice of Privacy Practices.

Signature: _____

OPTION TWO:

_____ I was offered a copy of the Practice's Notice of Privacy Practices, but did not want it.

Signature: _____

For Office Use Only:

_____ A good faith effort was made to provide a copy of the Practices' Notice of Privacy Practices to this patient and to obtain his/her acknowledgment of the same. The patient _____ accepted/ _____ declined the Notice and refused to sign this acknowledgement for the following reason:

Practice Representative: _____

Signature: _____ Date: _____