Family Medicine Associates
CLEBURNE • JOSHUA
A member of I-35 Capital Physicians Group

F3.2B

Family Medicine Associates, P.A.
Notice Of Privacy Practices Reciept

I acknowledge that I was provided with the Notice of Privacy Practices of the Medical Practice named at the top of this page.

Print Name of Patient: ______________________________

Signature of Patient: ______________________________

Date: ______________________________

Patient's Date of Birth: ______________________________

Patient's ID/Chart Number: ______________________________

For Personal Representative of the Patient (if applicable)

Print Name of Personal Representative: ______________________________

Describe Personal Representative: ______________________________

Relationship (parent, guardian, etc): ______________________________

Signature of Personal Representative: ______________________________

Date: ______________________________

For Practice Use Only:

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Signature of Practice Employee Date