Liberty Surgical Associates, PLLC
400 136th Ave. Holland, MI 49424 616-738-0470 Fax: 616-738-0498

Acknowledgement of Receipt

I acknowledge that I have reviewed a copy of the Notice of Privacy Practices of LIBERTY SURGICAL ASSOICATES, PLLC. I further acknowledge that I have had an opportunity to ask questions about this policy. The full policy is available online at www.libertysurgical.com and in our lobby.

Name _____

Signature_____ Date _____

If this acknowledgment is not signed by the patient, please sign below.

Name of person signing_____

Signature_____ Date_____

Witness_____

Contact Instructions for Liberty Surgical Associates

**please initial one of the below options

❑ I authorize the physicians and staff of LIBERTY SURGICAL ASSOCIATES to communicate any and all aspects of my medical care including (but not limited to) scheduled appointments, lab results, x-ray results, and financial information to the individuals listed below or left on the message machine.

Name:_____ Relationship: _____

Phone:_____

Name:_____ Relationship: _____

Phone:_____

Name:_____ Relationship: _____

Phone:_____

❑ I ***DO NOT*** want any information regarding my medical care left on my message machine

Signature:_____ **Date:**_____