MAX HEALTH MAINE, LLC
A FAMILY PRACTICE

MaxHealthMe
TERRY ANN SCRIVEN, MD

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I received and read a copy of the Notice of Privacy Practices.

Print Name:_____Date:_____

Signature:_____ Date of Birth:_____

Parent/Guardian's Name if client is a minor:_____

Complete the following only if the Patient refuses to sign the Acknowledgement:

Reason for refusal:_____

Practice Representative (sign):_____

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