Neurological Care Center of Montgomery, P. C.
1315 Mulberry Street
Montgomery, AL 36106

Notice of Privacy Practices Acknowledgment

I, ____, acknowledge that I have received a copy of the notice of privacy practices.

____
Name of Patient or Personal Representative (please print)

____
Signature of Patient or Personal Representative

____
Date

____
Relationship to Patient (or other authority to serve)

Please provide your: -* Identification
- *Insurance Cards (office personnel copy front and back)
- Any Authorization forms you have (If Applicable)
- Your Copay (If Applicable)
*** Required**