1130 Liberty Street SE Suite #2
Salem, OR 97302
503.339.7781

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND NO SHOW/CANCELLATION POLICY

I, (name of patient) _____,
acknowledge and agree that I have received a copy of Rejuvenation Therapy Pain Clinic's Notice of Privacy Practices and the No Show/ Cancellation Policy.

_____ _____
Patient Signature Date

_____ _____
Patient Legal Representative (if applicable) Date

_____ _____
Print Name of Legal Representative Relationship to patient