RECEIPT FOR POLICY DOCUMENTS

Name: ____________________________________ Date: ____________

Please initial:

_____ I have received a copy of Aroga Medical Associates' Privacy Policies brochure effective: 9/23/2013. I have reviewed it and am in agreement with the policies contained in it.

_____ I have received a copy of Aroga Medical Associates' Office Policies brochure, have reviewed it and am in agreement with the policies contained in it.

_____ I have received a copy of Aroga Medical Associates' Patients' Rights and Responsibilities brochure.

__________________________________ ____________

Patient Date

__________________________________ ____________

Parent or Guardian (Guarantor) Date