Acknowledgement of Receipt
University Pediatric Urology, PC
2100 W. Clinch Ave., Ste. 120
Knoxville, TN 37916
865-637-7290

______________________________________ ____________________

Name of Patient **Patient's Date of Birth**

Notice of Privacy Practices & Rights of Patients

I acknowledge that I have been given the opportunity to receive a copy of University Pediatric Urology, PC's Privacy Notice.

This notice is posted in the lobby of the office.

Initials____________

Notice of Financial Policy

I hereby acknowledge that I have read, understood and agreed to the Financial Policy.

Initials____________

______________________________________ ____________________

Patient/Parent or Legal Guardian Signature **Date**

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Relationship to Patient

RPO-0019-4