YOUR Migraine Care MISSOULA

2831 Fort Missoula Rd.
Physicians Building #2, Suite 104
Missoula, MT 59804

406-926-1300 | YourMigraineCare.com

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

Date: _____

I acknowledge that I was provided with a copy of the Your Migraine Care Missoula Notice of Privacy Practices.

_____ _____

Patient Name (print) Patient Signature

If completed by a patient's personal representative, please print and sign your name in the space below:

_____ _____

Personal Representative (print) Personal Representative's Signature

_____

Relationship

For Your Migraine Care Missoula use only

Complete this section if this form is not signed and dated by the patient or patient's personal representative.

I have made a good faith effort to obtain a written acknowledgement of receipt of Your Migraine Care Missoula's Notice of Privacy Practices but was unable to for the following reason:

☐ Patient refused to sign

☐ Patient unable to sign

☐ Other_____

_____ _____

Employee Name Date