



RECEIPT FOR POLICY DOCUMENTS

Name: _____

Date: _____

Please initial:

_____ I have received a copy of Aroga Medical Associates' Privacy Policies brochure, 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