Ventura Orthopedics

Acknowledgement of Receipt of Notice

Ventura Orthopedics Medical Group, Inc.
www.venturaortho.com
Administrator | 805-641-6415

Patient Name _____

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

(please check one)

☐ Yes ☐ No I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at:

_____

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate your relationship to the patient:

☐ Parent or guardian of minor patient
☐ Guardian or conservator of an incompetent patient
☐ Beneficiary or personal representative of deceased patient

Online Survey

Your feedback matters!

Please help us improve the patient experience by filling out a short survey that will be sent via text message or email. Your contact information will not be used for any other reason, including junk or spam mail.

☐ Yes, I would love to help.
☐ No, I do not wish to participate.

For Office Use Only:

☐ Signed form received by: _____