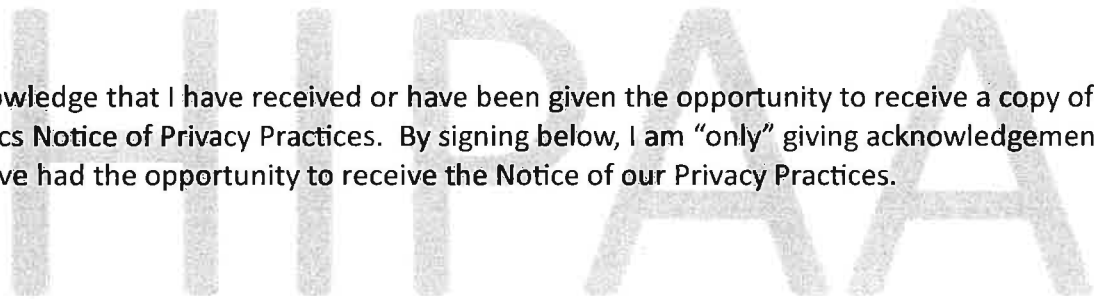


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ACKNOWLEDGEMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of A Caring Touch Pediatrics Notice of Privacy Practices. By signing below, I am “only” giving acknowledgement that I have received or have had the opportunity to receive the Notice of our Privacy Practices.



Patient Name (Type or Print)

Date

Signature

I have received the guidelines and policies of A Caring Touch Pediatrics and agree to read and comply with all the guidelines set forth. I understand that by ACT accepting my child or children as a patient, I am expected to follow these guidelines.

Signature

Date

MORIA N. BUSH, MD, FAAP – MARK L. PARROTT, MD – SHANDA L. MORRIS, MD