Crested Butte Pediatrics, LLC

419 Sixth Street, Suite 202
Crested Butte, CO 81224
970-349-3333

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

NAME OF PATIENT_____

DATE OF BIRTH_____

NAME OF PATIENT #2_____

DATE OF BIRTH_____

I hereby acknowledge that I received and reviewed Crested Butte Pediatrics' Notice of Privacy Practices.

ACKNOWLEDGEMENT OF NOTICE OF FINANCIAL POLICY

In addition, I have read, understood and agree to abide with Crested Butte Pediatrics' Financial Policy. By signing I acknowledge the terms and conditions listed in the policy.

_____
Signature of parent or guardian

_____
Date

_____
Witness name /Signature (Office staff member)