Anderson Integrative Medicine, PLLC
3031 S. Russell St. Missoula, MT 59801
Phone: (406) 493-0712 Fax: (406) 327-6702
email: matt@andersonmedicine.com

Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Patient/Client Name:_____
DOB: _____
SSN:_____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Anderson Integrative Medicine's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Matthew Anderson, FNP at (406) 493-0712; or by email at matt@andersonmedicine.com.

_____

Signature of Patient/Client **Date**

_____

Signature or Parent, Guardian or Personal Representative * **Date**

_____

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

❑ **Patient/Client Refuses to Acknowledge Receipt**:

_____

Signature of Staff Member **Date**