Orlando Neuro Therapy
1300 N Semoran Blvd
Orlando Fl 32807

Patient: _____
First and last name

Notice of Privacy Practices Acknowledgement

I acknowledge that I have been given a copy of or an opportunity to read the practice's Notice of Privacy Practices.

_____ _____
Patient's or Guardian's Signature Date

Patient Rights and Responsibilities Acknowledgement

I acknowledge that I have been given a copy of or an opportunity to read my patient rights and responsibilities provided by Orlando Neuro Therapy

_____ _____
Patient's or Guardian's Signature Date