



Mid-America  
**Orthopedics**  
Kansas City

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

By signing this form, I acknowledge that Mid-America Orthopedics has provided me with a copy of its Privacy Notice.

\_\_\_\_\_  
Patient/Guarantor Signature

\_\_\_\_\_  
Date

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**Office use only**

Mid-America Orthopedics KC staff should complete if patient had signed or had not signed the Privacy Notice:

1. Was the patient given a copy of the Privacy Notice?  
( )Yes ( )No
2. Please explain why the patient was unable to sign the Privacy Notice and document what the efforts were in trying to obtain the patients signature.

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Initials: \_\_\_\_\_