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www.legacypeds.com

Patient's Name

Date of Birth

Acknowledgement of Receipt/Review of Privacy Practices

- I have been provided with a Notice of Privacy Practices that provides me a more complete description of the uses and disclosures of certain health information. I understand that Legacy Pediatrics reserves the right to change their Notice of Privacy Practices and prior implementation and will provide an updated copy in the physician's office. I may request a copy of the updated Notice of Privacy Practices by calling the office or requesting a copy in person.

Parent/Legal Guardian Signature

Date

Relationship to Patient

Acknowledgement of Review of Office Policies

- I have read, understand, and agree to the terms outlined in the Legacy Pediatrics Office Policies. I have also read and understand the Legacy Pediatrics vaccination Policy.

Parent/Legal Guardian Signature

Date

Relationship to Patient