



106 Hyannis Drive
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**HIPAA RECEIPT OF NOTICE OF PRIVACY PRACTICES
 PAYMENT POLICY RECEIPT
 BILLING/NO SHOW POLICY RECEIPT
 WRITTEN ACKNOWLEDGEMENT FORM**

I, _____ have received a copy of the Holly Springs Pediatrics' Notice of Privacy Practices, Payment Policy and Billing/No Show Policy for review.

If parent is signing, please list child's/children's full name(s) and Date of Birth (DOB):

 Name DOB

 Name DOB

 Name DOB

 Name DOB

 Name DOB

 Name DOB

 Signature of Parent/Guardian

 Date

 Signature of Patient (18 years and older)

 Date