

YUN-CHING CHEN, M.D.
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ACKNOWLEDGMENT OF RECEIPT OF FORMS

I acknowledge that I have received copies of Privacy Policy and Office Policy forms from Dr. Chen's office. I understand all of the information I have been given and agree to the terms listed in the forms. I have also provided information in the Patient Information Form as accurately as possible on the date listed and will notify Dr. Chen's office as soon as there is a change in any of this information.

_____ NAME (PRINT) _____ (DOB)

SIGNATURE

DATE

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In the event Dr. Chen's office needs to contact you but cannot reach you directly, we may (*please circle either yes or no on ALL questions*):

___yes___ / ___no___ Leave confidential information regarding your health on your answering machine at home

___yes___ / ___no___ Leave confidential information regarding your health with a person identifying himself/herself as a family member

___yes___ / ___no___ Leave confidential information regarding your health on your voice mail at work identified with our name

___yes___ / ___no___ Fax confidential information regarding your health to your fax number (if available) identified in your Patient Information Form

___yes___ / ___no___ Send all nonurgent confidential information regarding your health to you by postage mail.