

**Patient Office Policy Acknowledgement Form**

I have read and understand the Patient Office Polices of Antonio A. Flores, M.D., P.A. By signing below I acknowledge receipt and communication of these policies with me and have been made aware that failure to comply with the Patient Office Policies may result in my termination as a patient for Antonio A. Flores, M.D. P.A. and associated medical providers. I understand that Antonio A. Flores, M.D. P.A. reserves the right to modify the Patient Office Policies as necessary and I reserve the right to request a printed copy of the Patient Office Policies.

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Patient/Legal Guardian Name (Print) Patient’s Date of Birth

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Patient/Legal Guardian Signature Date