Patient Acknowledgment of Provider

I understand that state rules require that I be adequately informed about the people who will be providing me medical services today. The purpose of this form is to provide me with names of people who will be treating me and the professional licenses they hold. For my treatment today, I will be seen by the following individuals:

MARIA ANTONIA ESPINEL	ARNP9311557
Name of Provider	**Professional License**

I understand that I can make an appointment to be seen by a different practitioner or physician at a later date or time if I so choose. I understand that I may request additional information regarding the below named person's professional qualifications if I so choose.

Acknowledgement and Signature

I have read this acknowledgment in its entirety. I acknowledge and agree that I have been given the opportunity to ask any questions and had all my questions answered to my satisfaction.

Printed Patient Name	**Date**	**Signature of Patient**