

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices for **North Mecklenburg Plastic Surgery, P.A.**

Name of Patient (Print or Type)

Signature of Patient

Date

Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

Relationship of Patient Representative to Patient

1. Can we call you at home? Yes No
2. Can we leave a message for you at home? Yes No
3. Can we leave a message for you at work? Yes No
4. With whom may we discuss your medical condition:

1. _____

2. _____

*This is an acknowledgement of receipt only.