

CHART NUMBER: _____

New England Dermatology & Laser Center

**ACKNOWLEDGEMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES**

It is the policy of **New England Dermatology & Laser Center** ("New England Dermatology") to provide all patients, or their parents, guardians or personal representatives, a copy of our current Notice of Privacy Practices prior to the date of the first service delivery, or upon the first visit to New England Dermatology after April 14, 2003, if feasible. This signed acknowledgement is to be filed in the medical record.

Patient's Name: _____

I have received New England Dermatology's Notice of Privacy Practices:

Date: _____

Signature: _____

If patient is a minor or is unable to sign for him or herself, then a parent, guardian or personal representative should sign on patient's behalf:

Date: _____

Signature: _____

Printed Name: _____

Relationship to Patient: _____

STAFF USE ONLY:

Note: If the patient or parent, guardian or personal representative does not sign this Acknowledgement of Receipt Form, the designated staff person should discuss the patient's reasons for not signing and should document below on this form both the staff person's efforts to get the signed Receipt and the patient's reason(s) for not signing. This note should be signed, dated and filed in the medical record.

Document reasons for patient not signing/efforts to obtain patient signature:

Signed by: _____

Print name: _____

Title: _____

Date: _____