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Patient Acknowledgement of Receipt/Review of the Notice of Privacy Practices

PATIENT NAME: _____

By signing this form, I am acknowledging my receipt and/or review of the posted Notice of Privacy Practices of Mitchell A. Fleisher, M.D., D.Ht., D.A.B.F.M., Homeopathic Family Medicine & Nutritional Therapy. I have been given the right to review the Notice of Privacy Practices prior to signing this form.

_____
Signature of Patient or Legal Guardian

_____
Print Name of Legal Guardian (if applicable)

_____
Print Name of Patient

_____
Date

Please kindly complete and return with the Patient Registration Form.