Family Podiatry of MD, LLC
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Acknowledgement of Receipt Of Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice.

_____ _____
Patient Name (please print) Date

_____
Parent or Authorized Representative

_____
Signature

Do you have a living will? YES_____ NO_____

Do you have a power of attorney or a person who can make medical decision on your behalf? YES_____ NO_____

If yes, please write name_____
If no, please explain why_____

If you would like to allow a representative(s) access to your medical records, please state the individuals name(s)
here:_____

Do you consent our office to leave medical information on the home/cell numbers provided on your registration form when necessary? Yes_____No _____