

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

I acknowledge that I received the Notice of Privacy Practices for ***Aesthetic Surgery Associates***

Name of patient (printed)

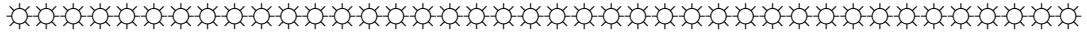
Signature of patient
(or patient's personal representative)

Date of receipt

*****Personal representative information (if applicable):**

Name of personal representative (printed)

relationship to patient



Name of Persons(s) we may release information to:

Name

Phone Number

Name

Phone Number

MAY WE LEAVE A MESSAGE ON YOUR ANSWERING MACHINE? (PLEASE CIRCLE ONE)

YES / NO

MAY WE LEAVE A MESSAGE AT YOUR WORK? (PLEASE CIRCLE ONE)

YES / NO

MAY WE LEAVE A MESSAGE ON YOUR CELL? (PLEASE CIRCLE ONE)

YES / NO