ACKNOWLEDGMENT OF RECEIPT
OF
Dr. Peter C. Smith’s
NOTICE OF PRIVACY and FINANCIAL PRACTICES

HIPAA

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

Financial Policy

I have been furnished a copy of or have read the Financial Policy of Dr. Peter C. Smith and understand all the terms, conditions and requirements applicable to my payment obligations to Dr. Peter C. Smith, DPM.

____ _____________

Patient Name (please print) Date

____

Signature

____

Parent or Authorized Representative

I authorize you to release my medical information to the following people on my behalf:

____

NAME RELATIONSHIP

____

NAME RELATIONSHIP

____

NAME RELATIONSHIP

____

NAME RELATIONSHIP