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