Four States Foot Clinic
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PATIENT 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 understood the Notice.

Date Signed: _____

Patient Name: _____ DOB: _____

Guardian Name (If other than patient) _____

Patient or Guardian Signature: _____

For Office use only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____
_____
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