



# Four States Foot Clinic

*Matthew B. Richins, DPM, DABPM*  
*Erick D. Studyvin, DPM, DABPM, AACFAS*

2630 Cunningham Ave.  
Joplin, MO 64804

Phone: 417-782-7500  
FAX: 417-782-7524  
FourStatesFootClinic.com

29 NW 1<sup>st</sup> Lane  
Lamar, MO 64759

## 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:** \_\_\_\_\_

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### 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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