Acknowledgement of Patient Privacy Practices

By signing below, I acknowledge that I have read a copy of Doctor's Weight Control's Notice of Privacy Practices and have been informed that I can request a copy of the Notice at any time by hard copy or by email. I have read and understand the Notice and I have had an opportunity to ask questions about the use and disclosure of my health information and other concerns about my health information

Please read the list below and make any requests at this time. If no request or correction is made, the procedure will remain as written.

1. Doctor's Weight Control reserves the right to call the given home/work phone number to confirm scheduled appointments the day prior to scheduled appointment: _____

2. If upon calling, we receive a voice mail message, we will say that we are calling to confirm an appointment with Dr. Bartemus with the scheduled time.

Name (Print): _____

Signature: _____ Date:_____

Staff Signature:_____ Date:_____