

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