



**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

We are required by law to provide you with a copy of our Notice of Privacy Practices. Our Privacy Practice provides information about how we may use and disclose protected health information about you. Protected health information may be disclosed or used for treatment, payment, or health care operation. Patients have the right to restrict the uses of their information but the practice does not have to agree to those restrictions. The patient may revoke this consent in writing at any time and all future disclosures will then cease. The practice may condition receipt of treatment upon the execution of this consent. To ensure that our records are accurate, please sign this form and return it to our receptionist to acknowledge that you have been provided.

Signature of Patient (or Legal Representative) \_\_\_\_\_

Signature of Staff \_\_\_\_\_

Date \_\_\_\_\_

**NO SHOW POLICY**

Scheduling medical appointments are very important. They allow the patient and the doctor to have a productive office visit. Appointments are necessary prerequisite for excellent patient care.

To better serve you and our patients better, please call 24 hours in advance if you are unable to keep your appointment to avoid any charges.

I have read and understand the NO SHOW POLICY as written above.

Signature of Patient (or Legal Representative) \_\_\_\_\_

**Thank You For Choosing Schaberg Dermatology**