

Acknowledgement of Receipt of Privacy Notice

Dr. Miguel Pupiales has provided me with the Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

Signed: _____ Date: _____

If not signed by patient please indicate relationship to patient (e.g., spouse)

Relationship: _____ Witnessed By: _____

Acknowledgment of 24 hour Notice Policy

I understand that Dr. Miguel Pupiales’ office, will apply a \$25.00 charge if I fail to give 24 Hour Notice or fail to show for an appointment.

Signed: _____ Date: _____

Acknowledgment of Physician Form Completion Policy

I acknowledge that I have received the Form Completion Policy from the office of Dr. Miguel Pupiales and I understand the terms set forth.

Signed: _____ Date: _____

Internal use Only:

If patient or Patient’s representative refuses to sign Acknowledgment of Receipt of Notice, please document the date and time the notice was presented to patient and sign below.

Presented on (date and time): _____

By (name and title): _____