# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Chico Dermatology
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I hereby acknowledge that I may request a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

The Providers and staff at Chico Dermatology may mail to my home or other designated location any items that assist them in carrying out treatment, payment, and health care operations, such as appointment reminders, insurance and billing items and laboratory results, among others, relating to my care.

The Providers and staff at Chico Dermatology may call my home or other designated location and leave a message or voice-mail in reference to any items that assist them in carrying out treatment, payment and health care operations, such as appointment reminders, insurance and billing items and laboratory results, among others, relating to my care.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

Print Address: _____

_____

If not signed by the patient, please indicate relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient