HD harrisonburg dermatology

# Patient Official Receipt

By signing this form, you acknowledge that this Medical Practice has given you a copy of its Notice of Privacy Practices. This notice explains how your health information will be handled. HIPAA, the Federal law concerning medical privacy, requires this notice.

I have received a copy of the Notice of Privacy Practices. The Medical Practice has given me the opportunity to ask any questions about this notice and all my questions have been answered.

_____ _____

Patient or Guardian Name Date

_____

Patient or Guardian Signature

**Provider Use Only**

If patient was not able to sign due to an emergency, or did not want to sign, please document if patient was given the notice and the reason why the patient did not sign below.

Patient was given the notice _____Yes _____No

Reason signature was not obtained_____

_____

_____

_____ _____

Staff Signature Date

2062 Pro Pointe Lane, Suite 100
Harrisonburg VA 22801
540 433-8700