VANISHING VEINS™

Notice of Privacy Practices
Hippa Privacy Policy
Acknowledgement of Receipt

By signing this form, you acknowledge receipt of the HIPPA Privacy Policy. Please let us know if you have any questions or concerns prior to signing this document.

Patient Name:____

Patient/Guardian Signature:_______________________________________ **Date:**__________________

Guardian Name (if applicable):____________________________________

INABILITY TO OBTAIN ACKNOWLEDGEMENT

If individual DID receive the Notice or Privacy Practices but did not sign this acknowledgement of receipt, state efforts and the reason why (refused, unable, left too soon, other):

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If individual did NOT receive the Notice of Privacy Practices explain why (emergency treatment, patient declined receipt, other):

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Signature of provider representative:__________________________________ **Date:**__________________

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