2361 Huntingdon Pike, Huntingdon Valley PA 19006
215.947.4990 · Fax 215.947.7660
www.DrDiBello.com

**Patient Instructions:**

Please complete by signing and dating the Patient's Acknowledgment's section below.

**RETURN THIS PAGE TO OUR OFFICE**

**Patient's Acknowledgement:**

**Please select and initial one (1) of the following two (2) options:**

1) _____ I hereby acknowledge that I have been offered, but declined, the opportunity to review the practice's NOTICE OF PRIVACY PRACTICES.

2) ______I hereby acknowledge that I requested, and have been provided with the practice's NOTICE OF PRIVACY PRACTICES and that I have read and fully understand the notice.

I have been provided the opportunity to ask questions about the notice and my questions have been answered to my satisfaction.

Patient Name (Print): ____________________________________________

Patient Signature: ______________________________ Date: ____________

If patient unable to sign, person legally authorized to sign: ______________________________

If patient is a minor, person authorized to sign: ______________________________

State reason patient unable to sign: ____________________

Relationship to patient:____________________

Signature of Witness: ____________________________ Date: ____________

**Who may we speak to regarding your medical care :**
**(PLEASE LIST: doctors, family, friends, etc.)**

______________________________

______________________________

______________________________

______________________________

______________________________

Form reviewed by patient:

| Date reviewed | Patient initials |
| --- | --- |
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Notice Effective Date: April 14, 2003