



PF-2000

Acknowledgement of Receipt of Notice of Privacy Practices

Associated Plastic Surgeons, P.C. reserves the right to modify the privacy practices outlined in the notice.

**Signature**

I have received a copy of the Notice of Privacy Practices for Associated Plastic Surgeons, P.C.

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient Representative  
(Required if the patient is a minor or an adult who is unable to sign this form)

\_\_\_\_\_  
Relationship of Patient Representative to Patient