PLASTIC SURGICAL ASSOCIATES, INC.
2000 WASHINGTON STREET/SUITE 444
NEWTON, MA 02462
AREA CODE 617-244-0990
FAX 617-969-4044

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I_____acknowledge that I have received or reviewed a copy of
(Name of Patient)
Plastic Surgical Associates Notice of Privacy Practices. This Notice describes how Plastic Surgical Associates may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

_____

(Signature of Patient, or Personal Representative) (Date)

_____ **(Relationship to Patient)**

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HEALTH CARE WAIVER

As a courtesy to our patients, we submit claims to most insurance companies. However, we are not responsible for obtaining referrals or collecting payment. If you require a referral and we have not received it on or before the day of your visit, payment will be your responsibility.

I acknowledge that if my health insurer does not pay for or denies medical services rendered to me at this office, I will be responsible for payment.

_____ _____

Member Name Date

_____

Signature