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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient please indicate:

Relationship:

____ Parent of guardian of minor patient

____ Guardian or conservator of an incompetent patient

____ Beneficiary or personal representative of deceased patient

Name of Patient: _____