Dominick A. Marino,O.D.,P.A.

PRACTICE NAME

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, _____ (Patient Name), have reviewed/received a copy of _____ (Practice Name)'s Notice of Privacy Practices.

HIPAA

_____ Signature of Patient / Guardian

_____ Date

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

CHECK ALL THAT APPLY:	YOURSELF	FATHER	MOTHER	GRANDFATHER	GRANDMOTHER	BROTHER	SISTER
DIABETES	☐	☐	☐	☐	☐	☐	☐
HIGH BLOOD PRESSURE	☐	☐	☐	☐	☐	☐	☐
HEART DISEASE	☐	☐	☐	☐	☐	☐	☐
STROKE	☐	☐	☐	☐	☐	☐	☐
ARTHRITIS	☐	☐	☐	☐	☐	☐	☐
CANCER	☐	☐	☐	☐	☐	☐	☐
GLAUCOMA	☐	☐	☐	☐	☐	☐	☐
CATARACT	☐	☐	☐	☐	☐	☐	☐
MACULAR DEGENERATION	☐	☐	☐	☐	☐	☐	☐