

# Michael Ascher, MD

191 Presidential Blvd Suite W10 / Bala Cynwyd, PA / 19004 / (646) 812-1421

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND POLICIES**

In order to comply with HIPAA standards, each practice must obtain a signed acknowledgement that each direct treatment patient has received its Notice of Privacy Practices and Policies or must document a good faith effort to provide the Notice and receive a written acknowledgement of receipt. This will allow practices to use or disclose confidential information (protected health information) for treatment, payment, or healthcare operations.

I have received a copy of the Notice of Privacy Practices and Policies from:

Michael Ascher, M.D.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

The authorization below is given on the patient's behalf because the patient is either a minor or unable to sign.

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF OFFICE POLICIES AND PROCEDURES**

I have received a copy of Michael Ascher, M.D.'s Notice of Office Policies and Procedures. I understand and agree to abide by them and consent to receive treatment. I understand and agree to abide by the late cancellation and missed appointment policy.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

The authorization below is given on the patient's behalf because the patient is either a minor or unable to sign.

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_