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DR. RICHARD E. ROTH, DO
EYE & FACIAL PLASTIC SURGEON
BOARD CERTIFIED

PRIVACY NOTICE ACKNOWLEDGMENT

Purpose: This form is used to document an individual's acknowledgement of receipt of our Privacy Practices Notice or when we have not obtained acknowledgement, our good faith effort to obtain the acknowledgement.

Patient Name: _____

Date of Birth: _____ Social Security Number: _____

Date of Admission: _____ Notice Version (Date): _____

Acknowledgement of receipt of Privacy Practices Notice

I, _____, acknowledge that I have received a Privacy Practice Notice Form:

Patient Signature: _____ Date: _____

HIPPA Approved Contacts: _____

Name Relationship Phone#

Name Relationship Phone#

IF NOT SIGNED: (Good faith effort to obtain acknowledgment of receipt.)

Describe your good faith effort to obtain the individual's signature on this form: _____

Describe the reason why the individual would not sign this form: _____

SIGNATURE: (Staff)

I attest that the above information is correct

Signature: _____ Date: _____

Print Name: _____ Title: _____

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EMPHYASIS OF THE EYES