



Bayview Dermatology and
Cosmetic Surgery, S.C.

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**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

***** YOU HAVE THE RIGHT TO REFUSE TO SIGN THIS ACKNOWLEDGEMENT*****

I, _____, have been given the opportunity to read a copy
Of this office's Notice of Privacy Practices. I also understand, that I have the right to request a copy of the
Notice of Privacy Practice for my records.

I prefer to be contacted:

By Mail: _____ or By Phone:

Home(_____) _____ work(_____) _____ cell(_____) _____

If, I do not answer the phone you may leave a message on my answering machine voicemail?
Yes _____ No _____

If want the office to release information to family member please provide name and phone number:

Name of Family Member _____

Phone number# _____

Patient Signature or Guardian if minor Date

For office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice Privacy Practice, but
acknowledgement could not be obtained due to the following:

- _____ Individual refused to sign
- _____ Communication barriers prohibited obtaining the acknowledgement
- _____ An emergency situation prevented us from obtaining acknowledgement

Other: _____

Practice Representative Date

