RECEIPT OF NOTICE OF PRIVACY PRACTICES

FROM: BUXMONT PULMONARY & SLEEP MEDICINE, PC

PATIENT NAME _____

DATE OF BIRTH _____

ACCOUNT NUMBER_____

DATE OF SERVICE_____

I acknowledge that I have received the Notice of Privacy Practice from Buxmont Pulmonary & Sleep Medicine, PC

_____

Patient's Signature

_____

Patient's authorized representative Relationship to patient

_____

Witness Signature Witness Job Title & Date