

### PATIENT ACKNOWLEDGEMENT

I acknowledge that I have been given an opportunity to review The Dermatology Clinic, PLLC's Notice of Privacy practices, and have been provided a copy if I desire one.

In order to assist The Dermatology Clinic, PLLC in protecting your privacy, please fill out the following:

Yes  No You may call me at the following numbers: \_\_\_\_\_  
\_\_\_\_\_

Yes  No You may call and leave messages regarding my care with my spouse  
\_\_\_\_\_ at the following number \_\_\_\_\_  
(Name)

Yes  No You may leave messages on my answering machine/voicemail.

Yes  No You may call me at work. (work phone # \_\_\_\_\_)

Yes  No You may leave messages regarding my care with the following persons:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

Yes  No You may photograph my skin for documentation purposes.

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**Signature of Patient (or Legal Guardian)**

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**Patient's Name (Please Print)**

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**Date**

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**Legal Guardian's Name (Please Print)**