NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT FORM

I acknowledge and agree that I have been provided a copy of the Notice of Privacy Practices for Mark Schoemann, M.D, and Schoemann Plastic Surgery Corporation that describes how my protected health information must be protected and my rights to access and control such information. I acknowledge and agree that I have reviewed the Notice of Privacy Practices in its entirety and been given the opportunity to ask any questions regarding the use or disclosure of my protected health information and my associated rights. I acknowledge and agree that I have had all my questions answered to my satisfaction.

PATIENT SIGNATURE (OR PERSONAL REPRESENTATIVE) **DATE**

_____

PRINTED NAME

_____

PERSONAL REPRESENTATIVE'S AUTHORITY (IF APPLICABLE)

FOR OFFICE USE ONLY

WE WILL MAKE A GOOD FAITH EFFORT TO OBTAIN A WRITTEN ACKNOWLEDGMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES PROVIDED TO EACH PATIENT. IF A PATIENT IS UNWILLING OR UNABLE TO SIGN THIS ACKNOWLEDGMENT, THE GOOD FAITH EFFORTS TO OBTAIN SUCH ACKNOWLEDGMENT AND REASON WHY THE ACKNOWLEDGMENT WAS NOT OBTAINED MUST BE DOCUMENTED.

REASON: