Vinod V. Pathy, MD, FACS

Aesthetic, Plastic, & Reconstructive Surgery

1525 Boston Post Road
Westbrook, CT 06498
860-333-1456 (O)
860-656-7104 (F)

1010 Village Walk
Guilford, CT 06437
860-333-1456 (O)
860-656-7104 (F)

330 Washington Street, Suite 410
Norwich, CT 06360
860-425-5300 (O)
860-425-5301 (F)

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: ____

Date of Birth: ____

I, ____, hereby acknowledge that I have received a copy of the Notice of Privacy Practices for the practice of Vinod V. Pathy, MD. I understand that if I have further questions or complaints, based upon the location of my services, I may contact:

Administrative Coordinator		Administrative Coordinator		Backus Physician Services
Vinod V. Pathy, MD, LLC		Vinod V. Pathy, MD, LLC		Billing Department
1525 Boston Post Road		1010 Village Walk		112 Lafayette Street
Westbrook, CT 06498	**or**	Guilford, CT 06437	**or**	Norwich, CT 06360
info@drpathy.com		info@drpathy.com		privacyofficer@wwbh.org

I also understand that I am entitled to receive updates, upon request, if the Notice of Privacy Practices is amended or changed in a material way.

____________________________________ ____________________
Signature Date

If not signed by the patient, please indicate below your relationship to the patient.

Patient Representative:

If you are the legally authorized representative of the patient, please **check the appropriate box** indicating your authority to act on the patient's behalf:		Parent
		Durable Power of Attorney for Health Care (attach proof of authority)
		Legally Authorized Representative (attach proof of authority)
		Personal Representative of the Estate (attach proof of authority)
		Other (specify and attach proof of authority)

<u>Individuals involved in your care or payment for your care</u>: Unless you object, we may disclose health information about you to a family member, close personal friend, or other person you identify who is involved in your care or arranging payment for your care. These disclosures are limited to information relevant to the person's involvement in your care or in arranging payment for your care.

FOR OFFICE USE ONLY

Patient Name: ____

Date of Birth: ____

A signed Notice of Privacy Practices was received:

[ ] Patient signed Notice of Privacy Practices

[ ] Patient representative signed Notice of Privacy Practices (and employee received verbal/written authorization from patient identifying said person as his/her representative)

A good faith effort was made to provide the patient ______________________________________ with our practice's Notice of Privacy Practices, but the patient did not acknowledge receipt because:

[ ] Patient declined to sign the Acknowledgment of Receipt of Notice of Privacy Practices

[ ] Patient condition or emergency situation did not allow it

[ ] Other (explain reason(s) why patient did not acknowledge receipt of Notice of Privacy Practice:

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________________________________	________________________
Name of Employee	Date