

Northville Podiatry
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ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

Patient Name (Please Print)

Signature

Date

Parent or Authorized Representative (if applicable)

DIRECTIONS FOR RELAYING CONFIDENTIAL INFORMATION TO PATIENT

I, _____, give **Northville Podiatry** and/or its staff my permission to contact me at the locations and phone numbers that are found on the Patient Registration form.

Patient / Guardian Signature

Date