ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES
FOR
NINA L. COLETTA, D.P.M, P.A.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or was given the opportunity to read) it. All of my questions have been answered and I understand all of its contents.

_____ _____

Patient Name (please print) Date

_____ _____

Parent or Authorized Representative (if applicable) Signature