Kenneth Sanders
Facial Plastic Surgery

How did you hear about us? _____

Preferred Pharmacy? (Name, Location) _____

Acknowledgement of the Receipt of the Notice of Privacy Practices

Patient's Name/Last	First	Middle	
Mailing Address	City	State	Zip
Telephone #	Email Address		
Date of Birth	Race/Ethnicity		
In Case of an Emergency, who may we notify:	Relationship to Patient		
Name	Telephone Number		

Kenneth W. Sanders, M.D. Facial Plastic Surgery (and our Medical Staff) will use and disclose your personal health information to treat you, to receive payment for the care we provide and for other health care operations. Health care operations generally include those activities we perform to improve the quality care. We have prepared a detailed **NOTICE OF PRIVACY PRACTICES** to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facilities, on our website and have copies available for distribution.

I acknowledge that I have been made aware of the NOTICE OF PRIVACY PRACTICES (copy in waiting room).

_____ _____

Signature of Patient/Guardian **Date**

_____

Patient/Guardian Name-Please Print