

MICHAEL M. PAPALIAN, MD

Plastic & Reconstructive Surgery

www.DrPapalian.com

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

KATHY K. BERNHARDT — PRIVACY OFFICER

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be available in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

Print Name \_\_\_\_\_

Signed \_\_\_\_\_

Date \_\_\_\_\_

Telephone \_\_\_\_\_

If not signed by the patient, please indicate relationship:

\_\_\_\_ Parent or guardian of minor patient

\_\_\_\_ Guardian or conservator of an incompetent patient

If Not signed by Patient, include:

Name of Patient

\_\_\_\_\_

Patient Address

\_\_\_\_\_

Street Address

\_\_\_\_\_

City, State and Zip Code

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