Please sign and send this with your Preliminary Medical History Questionnaire and front-and-back copies of your insurance card(s). The Notice of Privacy Practices is posted on this website.

Southwest BARIATRIC Surgeons

NOTICE OF PRIVACY PRACTICES RECEIPT

I acknowledge that I was provided with the Southwest Bariatric Surgeons, PLLC Notice of Privacy Practices. This document will be retained in your medical record.

Signature: _____ Date: _____
(Patient or person legally authorized to consent on patient's behalf)

For internal use only:

Print Name of Patient: _____ Date of Birth: _____

Additional Information: **(Please note patient's refusal to sign and reason)**

_____
_____
_____
_____
_____
_____

Employee Signature: _____ Date: _____