Eva Ritvo, M.D.

Patient Name: _____

Date of Birth:_____

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Notice of Privacy Practices of Eva Ritvo, MD, PA. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

_____ _____

Signature Date

AGREEMENT TO TERMS OF OFFICE POLICIES

I acknowledge that I have received and reviewed a copy of the Office Policies of Eva Ritvo, MD, PA and that I agree to its terms. The document provides in detail the policies and procedures followed by this practice, including cancellations, medication, fees and billing.

_____ _____

Signature Date