



# Bishnu P. Verma, M.D., P.A.

Internal Medicine

Diplomate ABIM in Internal Medicine

American College of Physicians  
Internal Medicine/Doctors for Adults

## Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received and understand Bishnu P Verma MD, PA's *Notice of Privacy Practices* containing a description of the uses and disclosures of my health information. I further understand that Bishnu P Verma MD, PA may update its *Notice of Privacy Practices* at any time and that I may receive an updated copy of Bishnu P Verma MD, PA's *Notice of Privacy Practices* by submitting a request in writing for a current copy of Bishnu P Verma MD, PA's *Notice of Privacy Practices*.

\_\_\_\_\_  
Printed Patient Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

*If completed by patient's personal representative, please print name and sign below.*

\_\_\_\_\_  
Printed Patient Personal Representative Name

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Patient Personal Representative Signature

\_\_\_\_\_  
Date



### **For Bishnu P Verma MD, PA Official Use Only**

Complete this form if unable to obtain signature of patient or patient's personal representative.

Bishnu P Verma MD, PA made a good faith effort to obtain patient's written acknowledgement of the *Notice of Privacy Practices* but was unable to do so for the reason documented below:

- Patient or patient's personal representative refused to sign
- Patient or patient's personal representative unable to sign
- Other \_\_\_\_\_

\_\_\_\_\_  
Employee Name (Printed)

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date