

Acknowledgement of Receipt

Robert A. Guida M.D., F.A.C.S.

I, _____ acknowledge receipt from Robert A. Guida, M.D., F.A.C.S., P.C., the following information

_____/_____/____ Notice of privacy practices
Initial Date (only if received)

_____/_____/____ Patient bill of rights
Initial Date (only if received)

_____/_____/____ I understand that any alterations to photos including
Initial Date Computer Imaging performed by Dr. Guida or his staff
are for demonstration purposes only and are not a
guarantee of final results

I understand that all medical providers are licensed in New York state.

Patient's signature

Received By:

Print name of staff member

Signature of staff member