

# FOOT AND ANKLE SURGICAL ASSOCIATES

## ACKNOWLEDGEMENT OR RECEIPT OF NOTICE OF PRIVACY PRACTICES

I ACKNOWLEDGE THAT I WAS PROVIDED WITH A COPY  
OF THE NOTICE OF PRIVACY PRACTICES

\_\_\_\_\_  
PATIENT NAME (PRINT)

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE

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HERE AT FOOT & ANKLE SURGICAL ASSOCIATES YOUR  
SCHEDULED APPOINTMENT IS VERY IMPORTANT.  
WE HAVE A POLICY FOR PATIENTS THAT "NO SHOW"  
OR FAIL TO GIVE **24 HOURS NOTICE** OF CANCELING  
OR RESCHEDULING OF THEIR SCHEDULED APPOINTMENT.

**THERE WILL BE A \$30.00 CHARGE FOR FAILURE TO FOLLOW  
THIS POLICY!**

I HAVE READ AND ACKNOWLEDGE THE ABOVE POLICY

\_\_\_\_\_  
PATIENT NAME (PRINT)

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE