

***Praveen Modi, M.D., P.C.***

*9857 Haggerty Rd  
Plymouth, MI 48170  
Phone: 734-680-8889  
Fax: 734-228-4028*

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**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF  
PRIVACY PRACTICES**

*By signing below, you have acknowledged that you have read and understand this consent and this office's **notice of privacy practices form**. You further acknowledge that you have received a copy of this office's **notice of privacy practices form** to take with you. If it is alright to leave a voicemail or message on answering machine for normal test results please initial \_\_\_\_\_.*

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PATIENT SIGNATURE

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DATE

I authorize the following people to give and receive medical information pertaining to myself (not required).

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**Documentation of Failure to Obtain Signed Acknowledgment**

On \_\_\_\_\_, 20\_\_\_\_, \_\_\_\_\_

Presented this acknowledgment of Receipt of Notice of Privacy Practices Form to

\_\_\_\_\_ (the patient). The Patient refused to provide a signature when requested.