

# Evan L. Feibusch, M.D., LLC

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## **Acknowledgment of Receipt of Notice of Privacy Practices and Office Policies**

Patient Name: \_\_\_\_\_ Birth date: \_\_\_\_\_

Maiden or other name (if applicable): \_\_\_\_\_

I acknowledge that I have received a copy of the Notice of Privacy Practices of Evan L. Feibusch, M.D., LLC, effective December 5, 2005.

I also acknowledge that I have read and agree to the terms of Dr. Feibusch's Office Policies. In particular, I understand that I am responsible for his regular fee for the time reserved for an appointment I miss without adequate notice as defined in his office policies.

Signature (patient or authorized representative): \_\_\_\_\_

Date: \_\_\_\_\_

Relationship/authority (if signed by authorized representative): \_\_\_\_\_