Acknowledgement of Receipt of
Notice of Privacy Practices

Kevin W. Louie, M.D. A Professional Corporation
2100 Webster Street, Suite 117, San Francisco CA, 94115

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signed: ______________________________ Date: ____________________

Print Name: ______________________________

If not signed by patient, please indicate:

Relationship: ☐ Parent or guardian of minor patient

☐ Guardian or conservator or an incompetent patient

☐ Beneficiary or personal representative of deceased patient

Name of Patient: ______________________________

Patient Disclosure

California Law Imposes disclosure requirements for Physicians that have financial interest in a facility to which they refer patients. In compliance with the law, please be advised that I, Kevin W. Louie, have financial interest in Pacific Heights Surgery Center of San Francisco.

If you prefer that surgery not be performed at Pacific Heights, please let me know so I can make other arrangements for you.

By signing below, you acknowledge that you have read and understand the above.

Signed: ______________________________ Date: ____________________

Print Name: ______________________________