DR. PETER M. WILUSZ DPM FACFAS

5730 Bella Rosa Blvd.
Ste. 200
Clarkston, MI 48348

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

Patient Name (please print) Date

Patient Signature

Signature of parent or authorized representative (if applicable)