COLORADO DERMATOLOGY
GROUP, PLLC

*Thank you for choosing Colorado Dermatology Group, PLLC for your healthcare needs.*

## ACKNOWLEDGEMENT OF UNDERSTANDING OF OFFICE POLICIES

My signature below indicates that I have read, understand and will comply with the information contained within these Office Policies. A copy of these policies is available upon request.

_____
Signature of Patient (or Legal Representative)

_____
Print Name

_____
Date

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We are required by law to provide a copy of our Notice of Privacy Practices. Please sign below to verify that you have reviewed and acknowledge our Notice. A copy of this Notice is available upon request.

_____
Signature of Patient (or Legal Representative)

_____
Print Name

_____
Date