

**PATIENT ACKNOWLEDGMENT**

Patient Name: \_\_\_\_\_

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices of

Boris A. Khaimov, DO  
Child, Adolescent and Adult Psychiatrist

\_\_\_\_\_  
Signature of Patient (or authorized representative)

\_\_\_\_\_  
Name of Patient (please print)

\_\_\_\_\_  
Date