Albert M. DeFabritus M.D.

352 7TH AVENUE Suite – 1003

NEW YORK, NEW YORK 10001

PLEASE SIGN

We reserve the right to charge for appointments missed or cancelled without 24 hours notification.

Date : _____

Signature : _____

Albert M. DeFabritus M.D.

352 7TH AVENUE Suite – 1003

New York, New York, 10001

Patient Acknowledgement of privacy notice :

I _____ have received and read a copy of the office privacy notice.

I am making the following special request for confidential communications.

_____

_____

_____

Signature Date