

Acknowledgement of Receipt

NEW YORK CENTER FOR PLASTIC SURGERY

Robert A. Guida M.D., F.A.C.S.

I, _____ acknowledge receipt from Robert A. Guida, M.D., F.A.C.S., P.C., the following information

_____/_____/____ Procedure information
Initial Date (only if received)

_____/_____/____ Pre and post-operative instructions
Initial Date (only if received)

_____/_____/____ Surgical prescriptions
Initial Date (only if received)

I understand that all medical providers are licensed in New York state.

Patient's signature

Received By:

Print name of staff member

Signature of staff member