



**SCOTT J. RUSCO, D.O., INC.**  
**PHYSICIAN & SURGEON**  
**BOARD CERTIFIED IN FAMILY PRACTICE**  
**6360 WEST 159TH STREET SUITES D & E**  
**OAK FOREST, ILLINOIS 60452**  
**708-535-6204 708-535-6431 (FAX)**

**Receipt of Notice of Privacy Practices  
Written Acknowledgement Form.**

I, \_\_\_\_\_, have received / read a copy of Scott J. Rusco, D.O., Inc.  
Patient Name  
Notice of Privacy Practices.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date