ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. **Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.**
2. **Obtain payment from third party payers.**
3. **Conduct normal health care operations such as quality assessments and physician certifications.**

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operation. I also understand that you are not required to agree to my requested restriction, but if you agree then you are bound to abide by such restrictions.

Patient Name (print) ____

Relationship to Patient____

Signature____Date____________

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Patient Name_________________________________Date of Birth______________

Address____

If the address provided above is not your home address or it is not a street address, please provide us with a street for purposes of ensuring payment, written communications.

Home #_________________________may we leave a message? **Yes____No____**

Work #_________________________may we leave a message? **Yes____No____**

Cell #__________________________may we leave a message? **Yes____No____**

Email __________________________may we send an email? **Yes____No____**

May we send an appointment reminder text message? **Yes____No____**

May we leave a message that you need pre-medication? **Yes____No____**

May we leave a message that you have an appointment? **Yes____No____**

I do not want a reminder left at all__________(initials)

I do not want a postcard sent________(initials)

__________ I understand that the office may charge me should I fail to keep my appointment oral communications _____

FOR OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on the *Notice of Privacy Practices* but was unable to do so as documented below.

Date_____________________Reason____Initials___________

Saved as: ORIGINAL Notice of Privacy Practices