HIPAA Acknowledgement

Please initial that you have read:

_____ By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations. You have the right to revoke this consent at any time by giving this office written notice of your revocation. Please understand that we could no longer file insurance claims for you and that it will not affect any action we took in reliance on this consent prior to receiving your revocation and that we may decline to treat or continue treating you if you revoke this consent.

_____ I acknowledge a copy of this office's Notice of Privacy Practices is available to me at my request.

_____ I hereby authorize payment to this practice of the insurance benefits otherwise payable to me and recognize and accept personal responsibility of any remaining balance.

Please check the following that apply:

☐ OK to leave a message regarding appointment, insurance information, call back requests, etc. on my home phone and/or cell phone.

☐ OK to leave a message regarding appointment, insurance information, call back requests, etc. with a family member.

☐ OK to leave a message regarding appointment, insurance information, call back requests, etc. on my work phone.

Please list any and all persons we can speak to on your behalf:

____

____

____

______________________________________ ____________

Signature of Patient (Guardian if patient is a minor) Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

List explanation above