

CONTACT INFORMATION

We would like to be able to send you appointment reminders by cell phone and e-mail.

Cell phone number with area code: _____

Carrier: _____ (Verizon, T-Mobile, AT&T, Sprint, other)

E-mail address: _____

Please check how we may contact you with other communications (check all that apply)

_____ Home _____ detailed message _____ call back # only _____

_____ Cell _____ detailed message _____ call back # only _____

_____ Work _____ detailed message _____ call back # only _____

NOTICE OF PRIVACY 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 information will be used to:

- 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.
- Obtain payment from multiple types of third-party payers.
- Conduct normal operations consistent with a physician's office. This includes treatment outcome studies, quality assessments and data analysis.

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

I acknowledge that I have reviewed the Notice of Privacy Practice Acknowledgement containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change notice of Privacy Practices. I may contact the office at any time to obtain a current copy of the Privacy Practices.

Patient Name: _____

Signature: _____ **Date:** _____