ANKLE & FOOT CARE CENTER
6671 W. INDIANTOWN RD #55
JUPITER, FL 33458
(561)747-0331

I HEREBY ACKNOWLEDGE MY RECEIPT OF THE PRIVACY POLICY ACT (H.I.P.P.A)

PRINT PATIENT NAME:_____

DATE: _____

MAY WE LEAVE MESSAGES ON YOUR HOME ANSWERING MACHINE OR VOICEMAIL ABOUT TEST RESULTS, ANSWERS TO YOUR QUESTIONS, APPOINTMENTS, BILLING QUESTIONS YOUR AND MEDICAL ISSUES PERTAINING TO YOU PODIATRIC HEALTH?

YES OR NO

MAY WE SPEAK TO YOUR SPOUSE OR SIGNIFICANT OTHER ABOUT YOUR PODIATRIC HEALTH?

YES OR NO

PRINT SPOUSES/SIGNIFICANT OTHER'S NAME:_____

ARE THERE ANY FAMILY MEMBERS OR FRIENDS THAT YOU'D LIKE FOR US TO SPEAK TO IF ASKED ABOUT YOU PODIATRIC HEALTH? IF SO, PLEASE WRITE DOWN THEIR NAMES, RELATION & CONTACT INFO?

1. _____

2. _____

3. _____

4. _____

PATIENT SIGNATURE: _____

NOTIFY ANKE & FOOT CARE CENTER OF ANY CHANGES

ACKNOWLEDGEMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

FOR

ANKLE & FOOT CARE CENTER

_____I acknowledge that I was provided a copy of the Notice of Privacy Practices, and I have read (or had the opportunity to read if I so choose) and understood the Notice.

_____I acknowledge that I was given the opportunity to accept the Notice of Privacy Practices and have chosen not to receive the Notice or have it explained to me.

_____ _____

Patient Name (please print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature