INDY PODIATRY
we love your feet
Dr. Michael J. Helms
Dr. Shelly F. Bowers
Dr. Kellie Higgins

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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

Patient Name (please print) Date

Parent or Authorized Representative (if applicable)

Signature

NEW HIPAA REGULATIONS

As of October 2002, HIPAA (Health Insurance Portability and Accountability Act) Regulations require a consent form to be signed by all patients regarding patient confidentiality.

I, _____, allow Dr Helms, Dr Bowers and/or any staff member to leave any of the following information regarding myself:

___ with my spouse, family member and/or dependent.

___ on answering machine/voice mail

Please initial each line:

_____ Lab work or lab results

_____ Appointment dates and times

_____ Account information (insurance, billing, collection information)

Patient's Signature Date