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

PODIATRISTS
FOOT SPECIALISTS

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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, Dr. Higgins, Dr. Chhiba 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

_____ Accountant information (insurance, billing, collection information)

_____

Patient's Signature Date