



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. 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