



NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient Name: _____

Date of Birth: _____ Social Security #: _____

By signing this form, you acknowledge that we have provided you with our Notice of Privacy Practices which explains how your health information may be handled in various situations including your treatment, payment of your bill, and our healthcare operations. If your first date of service with us was due to an emergency, we must try to provide you with our Notice and get your written acknowledgement for the Notice as soon as we can once the emergency has passed.

PLEASE CHECK ALL THAT ARE TRUE:

I have received the Notice of Privacy Practices (effective date _____).

Patient's (or Legal Representative's) Signature)

Date

Relationship of Legal Representative

For office use only

To be completed only if Acknowledgement is not signed.

1) Was the patient given a copy of the Notice of Privacy Practices?

Yes No

2) Please explain why the patient was unable to sign this Acknowledgement and our efforts to try to obtain the patient's signature.

Name/Title

Date



To our patients,

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to an address other than your home address.

The physicians and staff of south Florida Gastroenterology Associates, P.A. respect your privacy and wish to make all reasonable attempts to respect your wishes regarding your confidential information. With that in mind, please indicate your preferences for the areas noted below.

I wish to be contacted in the following manner (check all that apply)

- Home Telephone _____
 - O.K. to leave message with detailed information
 - Leave message with call-back number only

- Work Telephone _____
 - O.K. to leave message with detailed information
 - Leave message with call-back number only

- Written Communications
 - O.K. to mail to my home address
 - O.K. to mail to my work/office address
 - O.K. to fax to this number: _____

- Other individuals (family, friends, etc.) you may speak with about
 - My care or treatment My bill

Name	Relationship
_____	_____
_____	_____
_____	_____

_____	_____
Print Patient Name	Date of Birth
_____	_____
Patient Signature	Date

