PATIENT ACKNOWLEDGEMENT OF NOTICE of PRIVACY PRACTICES

Effective April 14, 2003, the federal HIPAA privacy rule requires our practice to comply with certain legal requirements designed to protect your personal health information. HIPAA gives individuals the right to request a restriction on uses and disclosures of protected health information (PHI). The individual is also provided the right to request confidential communications of PHI be made by alternative means, such as sending correspondence to the individual's office instead of home. We may need your written authorization to release PHI even if you are the one requesting the release.

By signing below I acknowledge that I have read Pain Care Consultant's Notice of Privacy Practices.

I wish to be contacted in the following manner.
Check all that apply:

Home Telephone____

- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only

Work Telephone____

- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only

Written Communication

- ☐ OK to mail to my home address
- ☐ OK to mail to my work / office

OK to fax to this number____

You can communicate information about me to:
Check all that apply:

- ☐ My spouse_______________________________________
- ☐ Family members__________________________________
- ☐ Caregivers_______________________________________
- ☐ Other____

*Emergency Contact person in the event we need to change/cancel your appointment.

Name_________________________________

Telephone#____________________________

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Patient or Legal Guardian Signature Date

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Print Name Relationship to Patient