FAIR OAKS ORTHOPAEDIC ASSOCIATES

ACKNOWLEDGEMENT OF HIPAA PRIVACY NOTICE

Patient Name:____
Patient Account # :____
Date of Registration:____

By signing this form, you acknowledge that Fair Oaks Orthopaedic Associates has provided you access to a copy of its HIPAA Privacy Notice, which explains how your health information will be handled in various situations. By law, we are required to have you sign this form on your first date of service with us.

If your first date of service with us was due to an emergency, we must try to provide you access to this notice and have you sign this form as soon as we can after the emergency.

Please specify by checking the appropriate answer below if we may leave health-related information (e.g., lab/radiology results, billing issues or other doctor-patient communications) with/on:

Home Answering Machine	_____Yes	_____No
Work Voicemail	_____Yes	_____No
Personal/Work Email	_____Yes	_____No
Provide Email Address:_________________________________		
Cell Phone	_____Yes	_____No
Relative or Other Person Living With You	_____Yes	_____No

Please note that if the above section is not completed, we will assume that we have your approval to contact you using any one of these methods.

[ ] The Practice has provided me with a copy of its Privacy Notice.
I acknowledge that I have read, understand and agree to the above.

[ ] I have read the Privacy Notice and DO NOT AGREE to its provisions.

____ __________
Patient's/Guardian Signature Date

FOR PRACTICE STAFF TO COMPLETE IF ACKNOWLEDGEMENT FORM NOT SIGNED:

1. Does patient have a copy of the Privacy Notice? _____Yes _____No
2. Please explain why the patient was unable to sign an acknowledgement form and the Practice's efforts in trying to obtain the patient's signature:

____________ ____________
Employee's Initials Date