

**Office of Adrienne C. Sabin, DPM**

**Acknowledgment of receipt of Notice of Privacy Practices**

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 understood the notice.

In general, the HIPPA Privacy Rules give 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 is made by alternative means, such as sending correspondence to the individual's home or office.

I wish to be contacted in the following manner, check all that applies and fill in necessary information.

<input type="checkbox"/> Home Telephone: _____	<input type="checkbox"/> Address (mail to): _____
<input type="checkbox"/> Leave message with detailed information	_____
<input type="checkbox"/> Leave message with call back number only	_____
<input type="checkbox"/> Leave appointment reminders	_____

<input type="checkbox"/> Work Telephone: _____	<input type="checkbox"/> EMAIL: _____
<input type="checkbox"/> Leave message with detailed information	<input type="checkbox"/> Leave message with detailed information
<input type="checkbox"/> Leave message with call back number only	<input type="checkbox"/> Leave message with call back number only
<input type="checkbox"/> Leave appointment reminders	<input type="checkbox"/> Leave appointment reminders

**Financial Policy**

I understand that I am financially responsible for all charges not covered by my insurance company.

I have been advised that the bank fee for returned checks is \$35.00

I acknowledge that a late fee of \$15.00 will be added to all past due statements.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Parent or Authorized Representative (if Applicable): \_\_\_\_\_

Signature: \_\_\_\_\_