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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 Bowers 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

_____ Account information (insurance, billing, collection information)

____

Patient’s Signature Date