LAKEVIEW FAMILY FOOT CARE
NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

PATIENT NAME: ______________________ PATIENT DOB: __________

I UNDERSTAND THAT, UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 ("HIPPA"), I HAVE CERTAIN RIGHTS TO PRIVACY REGARDING MY PROTECTED HEALTH INFORMATION. I UNDERSTAND THAT THIS INFORMATION CAN AND WILL BE USED TO:

1) CONDUCT, PLAN AND DIRECT MY TREATMENT AND FOLLOW-UP AMOUNG THE MULTIPLE HEALTHCARE PROVIDERS WHO MAY BE INVOLVED IN MY TREATMENT DIRECTLY AND/OR INDIRECTLY.

2) OBTAIN PAYMENT FROM THIRD-PARTY PAYERS.

3) CONDUCT NORMAL HEALTHCARE OPERATIONS SUCH AS QUALITY ASSESSMENTS AND PHYSICIAN CERTIFICATIONS.

I HAVE RECEIVED, READ AND UNDERSTAND YOUR NOTICE OF PRIVACY PRACTICES CONTAINING A MORE COMPLETE DESCRIPTION OF THE USES AND DISCLOSURES OF MY HEALTH INFORMATION. I UNDERSTAND THAT LAKEVIEW FAMILY FOOT CARE HAS THE RIGHT TO CHANGE ITS NOTICE OF PRIVACY PRACTICES FROM TIME TO TIME AND THAT I MAY CONTACT THE OFFICE AT ANY TIME TO OBTAIN A CURRENT COPY OF THEIR NOTICE OF PRIVACY PRACTICES.

I UNDERSTAND THAT I MAY REQUEST IN WRITING THAT YOU RESTRICT HOW MY PRIVATE INFORMATION IS USED OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS. I ALSO UNDERSTAND YOU ARE NOT REQUIRED TO MY REQUESTED RESTRICTIONS, BUT IF YOU DO AGREE THAT YOU ARE BOUND TO ABIDE BY SUCH RESTRICTIONS.

______________________________ ______________

PATIENT SIGNATURE OR LEGAL GUARDIAN DATE

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement form, but was unable to do so as documented below.

______________ ______________ ______________

Date: Initials: Reason: