**HIPPA**
**Patient Acknowledgement**

Date: _____

I understand I have certain rights to privacy regarding my protected health information. I understand by signing this consent I authorize you to use and disclose my protected health information to carry out: Treatment (including direct or indirect treatment by other healthcare providers); obtaining payment from third party payers (e.g. my insurance company (if applicable)).

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA?

- □ First name only
- □ Proper Sir Name
- □ Other _____

HOW DO YOU WISH TO BE CONTACTED REGARDING YOUR HEALTHCARE, UPCOMING APPOINTMENTS, ETC.?

- □ Email confirmation – Email address: _____
- □ Text confirmation – Cell #: _____
- □ Home Phone confirmation
- □ Cell Phone confirmation
- □ Any of the above

In signing this HIPPA Patient Acknowledgement Form, I acknowledge and authorize that this office may recommend products or services to promote my improved health. This office may or may not receive third party remuneration from these affiliated companies.

_____ _____

Please **PRINT** your name Please **SIGN** your name