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.

☐ Home Telephone: ________________

☐ Leave message with detailed information

☐ Leave message with call back number only

☐ Leave appointment reminders

☐ Address (mail to):

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☐ Work Telephone: ________________

☐ Leave message with detailed information

☐ Leave message with call back number only

☐ Leave appointment reminders

☐ EMAIL: ________________________

☐ Leave message with detailed information

☐ Leave message with call back number only

☐ 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: ____