OCEAN Orthopedic ASSOCIATES

OCEAN Spine AND ADULT RECONSTRUCTION

Pyramid MRI

Acknowledgement of HIPAA Privacy Notice and
Designation of Disclosure

Acknowledgement of Practice's Notice of HIPAA Privacy:

_____ _____/_____/_____ _____

Name of Patient **Date of Birth** **Account#**

Address

☐ **I have been provided with a private policy brochure.**

Designation of Certain Relatives, Close Friends and Other Caregivers:

I agree that the practice may disclose certain information regarding my health to a family member, close personal friend or other caregiver, since such person is involved with my healthcare or payment relating to my healthcare. In that case, the physician practice will disclose only information that is directly relevant to that person's involvement with my healthcare or payment relating to my healthcare. I wish to be contacted in the following manner (check all that apply):

Telephone, Written and Fax Communication

Home Telephone Number:
(_____)_____

X O.K to leave message with detailed information

X Leave message with call back

Work Telephone Number:
(_____)_____

X O.K. to leave message with detailed information

X Leave message with call back numbers only

Cellular Phone Number:
(_____)_____

X O.K to leave message with detailed information

X Leave message with call back

Written Communication:
X O.K. to mail to my home address (Such as postcards or letters)

X O.K. to mail to my work or office

Fax Communication:
(_____) _____
X O.K. to fax this number

I designate the following persons listed below as persons involved with my healthcare for the purpose of practice making the limited disclosures described above. I understand that I am not required to list anyone. I also understand that I may change this list at any time in writing.
No Show/Missed appointments $25.00 fee - Missed CoPay $10.00 fee.

Name_____ Name _____

Name_____ Name _____

_____ _____/_____/_____

Signature Date