NSADVANCEDSURGERY

NOTICE OF PRIVACY PRACTICES

I UNDERSTAND THAT UNDER THE HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPAA), I HAVE CERTAIN RIGHTS REGARDING MY PROTECTED HEALTH INFORMATION.

I UNDERSTAND THAT THIS INFORMATION CAN AND WILL BE USED TO:

- CONDUCT, PLAN AND DIRECT MY TREATMENT AND FOLLOW-UP AMONG THE MULTIPLE HEALTHCARE PROVIDERS WHO MAY BE INVOLVED IN THAT TREATMENT DIRECTLY AND INDIRECENTLY.
- OBTAIN PAYMENT FROM THIRD PARTY PAYERS
- 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 THIS ORGANIZATION HAS THE RIGHT TO CHANGE ITS “NOTICE OF PRIVACY PRACTICES” FROM TIME TO TIME AND THAT ANY CHANGES WILL BE POSTED IN THE DOCTORS OFFICE AND THAT I MAY CONTACT THIS ORGANIZATION AT ANY TIME TO OBTAIN A CURRENT COPY OF THE “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 HEALTHCARE OPERATIONS. I ALSO UNDERSTAND AND YOU ARE NOT REQUIRED TO AGREE TO MY REQUSTED RESTRICTIONS, BUT IF YOU DO AGREE THEN YOU ARE BOUND TO ABIDE BY SUCH RESTRICTIONS.

PRINT NAME: ________________________________ DATE: _____________

SIGNATURE: ____

RELATIONSHIP TO PATIENT: _______________________________________

I ATTEMPTED TO OBTAIN THE PATIENTS SIGNATURE IN ACKNOWLEDGMENT ON THIS NOTICE OF PRIVACY PRACTICES, BUT WAS UNABLE TO DO SO AS DOCUMENTED BELOW.

DATE: ___________ INITIALS: ______

REASON: ____