Dr. Christopher A. Seda, DPM, FACFAS
ACKNOWLEDGING RECEIPT OF NOTICE OF PRIVACY PRACTICES

In order to comply with specific rules regarding HIPPA (Health Insurance Portability & Accountability Act), we ask that our patients review and sign a privacy and security of health information document. A complete copy of our privacy policy is posted in the waiting area of our ofice. A copy of the same is available for you to take home with you should you desire. The Notice describes how your health information may be used or disclosed. Please read it carefully. The Notice may be changed at any time. Please see the receptionist for the most recent copy.

It is the policy of Lebanon Valley Foot and Ankle Center and its staff not to release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, cell phone and/or pager. Whenever returning telephone calls and an answering machine picks up, we cannot leave a message if the NAME and TELEPHONE NUMBER is not on the recorded message identifying the resident. Information will not be left with an unauthorized person who may answer the telephone.

PATIENT

Date_____ Patient Signature_____

Date of Service_____ Print Name_____

Date of Birth_____

IF CHILD, PERSONAL REPRESENTATIVE/GUARDIAN/INSURED: *As the Personal Representative of the above individual. I acknowledge receipt of the Notice on his/her behalf.

Date_____ Personal Representative Signature_____

Relationship to Patient_____ Print Name_____

☐ Patient/Personal Representative, or person who accompanied the patient refused to sign. reason why, if given:_____

COMMUNICATION & RELEASE OF INFORMATION. To facilitate our calling procedures, please complete the folowing:

I authorize the office of Dr. Christopher Seda, DPM, FACFAS, to leave medical information pertainng to my care by the folowing methods and understand that it is my option to change or revise this information at any time. It is my responsibility to notify the office of these changes.

Home Telephone ☐ YES ☐ NO Answering Machine ☐ YES ☐ NO

Work Telephone ☐ YES ☐ NO Cell Phone and/or Voice Mail ☐ YES ☐ NO

Send medical records/forms to another entity (hospital, doctor, insurance company) if requested. The patient must sign a records release form. ☐ YES ☐ NO

Please list the names of people authorized to receive your confidential medical information and their relationship to you (spouse, parent, sister, brother, fiance, girlfriend, boyfriend, etc.).

Name_____ Relationship_____

OFFICE USE ONLY: ☐ NOPP Acknowledgement handed to the person acompanying patient to be given to patient's personal representative.
☐ Patient unable to sgn. No personal representative was available.

Signature_____ Date_____