835 7th St Suite 5,Clermont FL 34711

Acknowledgement of Notice of Privacy Practices

Health Insurance Portability and Accountability Act of 1996(HIPAA)

I hereby acknowledge that I received Orange Doc Family Medicine, PLLC Notice of Privacy Practices.

\*Print Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*SS#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Social Security Number

\*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE OF PATIENT OR PATIENT REPRESENTITIVE

Your Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact Information**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What is your insurance preferred laboratory**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Documentation of Good Faith Efforts

To obtain patient’s acknowledgement that they received provider’s

Notice of Privacy Practices

(**For use when acknowledgement cannot be obtained from the patient**):

The patient presented on \_\_\_\_\_\_\_\_\_\_\_ and was provided with a copy of Covered Entity’s Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgement of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

Patient Refused to sign\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient was unable to sign or initial because\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The patient had a medical emergency, and an attempt to obtain the acknowledgement will be made

at the next available opportunity.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_

 \*\* Signature of Employee Witnessing Signature

**REFILLS:**

Our office DOES NOT prescribe or refill long term narcotic pain medications for any reason. If you require long term use of a narcotic pain medication as part of your treatment, you should have these medications managed by a specialist in narcotic pain management.

\*For all other Medication Refills, please notify our office at least two (2) business days in advance.

**\*Signature of Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**