\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

«FirstName» «LastName» «DOB»

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES, FINANCIAL AND OFFICE POLICY

I acknowledge receipt of Pedicorp PC’s Practice Policies and agree to abide by its guidelines. I certify that the information provided on the **patient registration sheet** is true and correct. I understand it is my responsibility to notify Pedicorp, PC of any changes on the **patient registration sheet.** Pedicorp imports medical information from other healthcare providers that participate in this information sharing network, your child is automatically opted in, to opt out you will need to complete an opt-out form. Our practice does not export information to this network

AND

I, the undersigned, assign directly to Pedicorp, P. C., all medical benefits if any, otherwise payable to me for services rendered to the above listed person. I understand that I am financially responsible for all charges whether or not paid by the insurance. I hereby authorize the healthcare provider to release all information necessary to secure the payment of benefits I authorize the use of this signature on all my insurance submissions.

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I**, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,** hereby acknowledge that I have received (or been offered) a copy of the Notice of Privacy Practices. I understand that if I have further questions or complaints I may contact:

J. Christopher Schuck, MD

Compliance Officer

860-285-8251

I also understand that I am entitled to receive an update upon request if Pedicorp’s Notice of Privacy Practices is amended or changed in a material way.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***FOR PATIENTS 18 YEARS AND OVER: I understand by signing this form, I give Pedicorp, P. C. authorization to discuss my healthcare with my parent/legal guardian in the same manner prior to my becoming a legal adult. I also understand that I may revoke this authorization by submitting a written request.***

***Patient signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_***

TO BE COMPLETED BY ENTITY IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGEMENT FROM PARENT/GUARDIAN/PATIENT.

On \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, I attempted to obtain a written acknowledgment of receipt of the Notice of Privacy Practice from the above-named patient, but was unable to because:

{ } Declined to sign this written acknowledgement {} Did not understand written acknowledgement { } other specify

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of staff member: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ date: \_\_\_\_\_\_\_\_\_\_\_\_\_

07/18/2018 combo signature for HIPPA, Practice policy, form fee (office, forms, labels, & signs)

