

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I, _____, understand that as part of my health care, Mohawk Valley Orthopedics, P.C. originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, as well as plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment;
- A means to facilitate communication among the many healthcare professionals who contribute to my care;
- A source of information for applying my diagnosis and surgical information to my bill;
- A means by which a third-party payer can verify that services billed were actually provided; and
- A tool for healthcare operations of Mohawk Valley Orthopedics, P.C. such as assessing quality care and reviewing the competence of healthcare professionals

I understand that as part of Mohawk Valley Orthopedics, P.C. treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity for the purposes stated above.

I understand and have been provided with a *Notice of Privacy Practices* that provides a more complete description of how Mohawk Valley Orthopedics, P.C. may use and disclosure my protected healthcare information. I further understand that Mohawk Valley Orthopedics, P.C. reserves the right to change its *Notice of Privacy Practices*. Should Mohawk Valley Orthopedics, P.C. change its *Notice of Privacy Practices*, an amended copy will be sent to the address I have provided.

I agree that Mohawk Valley Orthopedics, P.C. may do the following unless I specifically give direction prohibiting such activity:

Send visit reminders and test results to the address I have provided.

Send routine correspondences, such as billing statements, to the address I have provided.

Leave messages on an answering machine or voicemail associated with the telephone numbers I have provided to either confirm appointments or to request that I call the Practice on medical or billing matters.

Patient's Signature or Signature of Personal Representative

Date

FOR OFFICE USE ONLY

Receipt received by _____

Patient refused to sign receipt. _____ (Signature of Practice Representative)