ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that, under the Health Insurance Portability& Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information.

By signing this form, I acknowledge that:
- I have received, read, and understand your Notice of Privacy Practices (abbreviated or full version) containing a description of the uses and disclosures of my private health information (PHI).
- I understand that my private health information (PHI) can be used for treatment, payment, and healthcare operations by Stephanie Pavlik, O.M.D.
- I understand that I may request in writing that you restrict how my PHI is used or disclosed to carry out treatment, payment, or health care operations.
- I also understand you are not required to agree to my requested restrictions, but if you do agree that you are bound to abide by such restrictions.
- I understand that my signature does not authorize disclosure, but only acknowledges that I have received a copy of the Notices of Privacy Practices.
- I understand that Stephanie Pavlik, O.M.D. has the right to change her Notice of Privacy Practices from time to time and that I may contact Dr. Pavlik at any time at the address above to obtain a current copy.
- I understand and acknowledge that the office of Stephanie Pavlik, O.M.D. may place reminder phone calls, texts, or emails before a scheduled appointment or in regards to my health care condition. I agree to receiving these contacts.

Patient Name (print) ____

Signature ____

Relationship to Patient ____
(If signing on behalf of a minor.)

Date ____

If applicable, please indicate your affirmative preferences below:

____ Yes, I would like a paper copy of these HIPAA/Privacy policies given to me.

___ Stephanie Pavlik, O.M.D. and her office staff have permission to share my Private Health Information with the following individual(s):

Name (print) ______________________________________ Relationship to Patient _________________

Name (print) ______________________________________ Relationship to Patient _________________

Name (print) ______________________________________ Relationship to Patient _________________

OFFICE USE ONLY
I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

DATE: ___________ INITIALS: ________ REASON: ____

Stephanie Pavlik, O.M.D.
1701 County Road, Suite N
Minden, NV 89423
775-400-1371

PATIENT PRIVACY – HIPAA

To protect your privacy, please complete the following form:

Please print the address of where you would like your billing statements and/or correspondence from our office to be sent:

____

Do you want all correspondence from our office marked “CONFIDENTIAL”:

Yes____________No_____________

Please print the telephone number(s) where you want to receive calls about your appointments or other health care information. (If listing your cell phone number, please be aware that this is not a secure line.)

____________________________________ ____________________________________

Can confidential messages (appointment reminders, etc.) be left on your:

Telephone answering machine Yes____________No_____________

Voicemail Yes____________No_____________

Text Yes____________No_____________

Email Yes____________No_____________

Patient Name (print) ____

Signature ____

Relationship to Patient ____
(If signing on behalf of a minor.)

Date ____