NEAT FEET
Podiatry Laser Center
The specialist in Nail Fungus

S. Chris Horine, DPM, FACFAS
Gerald D. Austin Jr., DPM, AACFAS

DATE: ______/______/2009

NOTICE OF PRIVACY PRACTICES (HIPAA)

We are required to ask you to sign this Acknowledgement of Notice of Privacy Practices.

There is a 4-page, copy of our Notice of Privacy Practices, which provides a detailed description of what we do with health and personal information that we have about you. It also explains your rights, as a patient, for getting access to that information and controlling its use and disclosure. You may sit in our office and review this information. Please ask the front desk for a copy if you wish to receive it.

I UNDERSTAND I AM ENTITLED TO RECEIVE A COPY OF THE NOTICE OF PRIVACY PRACTICES

______________________________	______________________________
PATIENT NAME (PLEASE PRINT)	**SIGNATURE OF PATIENT/PARENT/ RESPONSIBLE PARTY**
______________________________	______________________________
PRINT NAME OF PARENT AND/OR RESPONSIBLE PARTY (IF APPLICABLE)	**RELATIONSHIP TO PATIENT**

****FOR OFFICE USE ONLY****

[ ] Per HIPAA regulations, we attempted to obtain, from the patient named above, a signed Acknowledgement of Receipt of Notice of Privacy Practices, but the signed acknowledgement could not be obtained because:

[ ] Patient/Responsible Party refused to sign with no stated reason.
[ ] Patient/Responsible Party refused to sign for their stated reason of :

____

____________________	______________________________
DATE	STAFF SIGNATURE

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