HIPAA

Date: _____._____._____

PATIENT SECTION PATIENT SECTION PATIENT SECTION PATIENT SECTION PATIENT SECTION PATIENT SECTION PATIENT SECTION

TELEPHONE:

Location	Can we call you at?		Can we leave a message at?	
Home:	❍ Yes	❍ No	❍ Yes	❍ No
Work:	❍ Yes	❍ No	❍ Yes	❍ No
Cell:	❍ Yes	❍ No	❍ Yes	❍ No
Other: _____	❍ Yes	❍ No	❍ Yes	❍ No

MAIL:

May we send mail to your home address? ❍ Yes ❍ No If no, please provide an alternate mailing address below:

Address: _____

Street City State Zip Code

PERSON(S):

Other than you, your insurance company(s), and healthcare provider(s) involved in your medical care, please specify whom we can talk to regarding your healthcare information:

❍ **Spouse:** **Name: _____** **Telephone #: _____._____._____**

❍ **Caretaker:** **Name: _____** **Telephone #: _____._____._____**

❍ **Child:** **Name: _____** **Telephone #: _____._____._____**

❍ **Parent:** **Name: _____** **Telephone #: _____._____._____**

❍ **Attorney:** **Name: _____** **Telephone #: _____._____._____**

❍ **Caseworker:** **Name: _____** **Telephone #: _____._____._____**

❍ **Other:** **Name: _____** **Telephone #: _____._____._____**

CONFIDENTIALITY: If you have any health information that you would like to keep confidential from any person(s), please specify:

Name: _____ **Information: _____**

Name: _____ **Information: _____**

I, the undersigned patient, fully acknowledge that I have been given ample opportunity to request alternative means of communication of my protected health information. I fully acknowledge that I have been given ample opportunity to request restrictions on the use and/or disclosure of my protected health information. In addition, I, the undersigned patient, fully acknowledge that I have received a copy of the Notice of Privacy Practices for Virginia Interventional Spine Associates.

_____ _____ _____._____._____

Patient or Representative Signature Witness Signature Date

_____ _____

Print Name Relationship to Patient

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GOOD FAITH EFFORT:

The patient identified above was provided with a copy of the Notice of Privacy Practices for Virginia Interventional Spine Associates on this date. A good faith effort has been made to obtain written acknowledgement of the patient's receipt of the Notice of Privacy Practices, however, acknowledgement has not been obtained because:

❍ Patient was unable to sign because: _____

❍ Patient was unable to sign because of a medical emergency. Virginia Interventional Spine Associates will attempt to obtain acknowledgement as soon as practicable.

❍ Patient refused to sign the acknowledgement of receipt of the Notice of Privacy Practices.

❍ Other: _____

_____ _____._____._____

Staff Signature Date