Patient Name: _____ DOB: _____

Patient Acknowledgement Form

When you visit the Practice, it is very important that you feel safe in telling your physician personal information that may be required to fully diagnose or treat a problem. The Practice has strict policies and procedures to protect the confidentiality of the information that you have entrusted to us. The Health Insurance Portability and Accountability Act ("HIPAA") rules require that the Practice provide all of our patients with our Notice of Privacy Practices on their first visit. (**A copy is available upon request and on our website for viewing**). The Notice describes how the medical information we receive from you may be used or disclosed by the Practice and your rights related to your access to this information.

Please sign below that we have provided you the opportunity to request a copy of our notice to review. If you have any questions about our Privacy Practices, please feel free to contact our Privacy Officer. Thank you for your cooperation.

I acknowledge that I have been given the opportunity to review a copy of the Practice's Notice of Privacy Practices and ask questions.

Signature of Patient or Personal Representative: _____ Date: _____
If Personal Representative, give relationship to patient: _____

Please Tell Us How to Contact You to Discuss Your Medical Care

It is our policy to not release a patient's confidential and/or unauthorized information by telephone or voice mail except for appointment confirmation. Whenever returning phone calls, we do not leave a message in voice mail if the name or telephone number is not on the recorded message to identify the residence. Information will not be left with an unauthorized person who may answer the telephone. If you would like to have information released to someone other than yourself, please complete the following:

I authorize the VEIN Atlanta, LLC, to leave medical information/correspondence pertaining to my care by the following methods and will assume responsibility to notify the Practice, in writing, whenever this information changes.

Home telephone: yes____ no____ Cell phone: yes___ no____
Voice Mail/Answering machine: yes____ no____ Work phone: yes____ no____
May we fax your medical records to your referring doctor? yes____ no____
May we contact you by email? If yes, please circle your selection: home email or work email
Please list names of people with whom we can discuss your medical care:
Name(s) & Relationship _____
_____

It is our policy to contact our patients within two business days with a reminder of an upcoming appointment. Please tell us your preferred method of contact regarding these types of calls.
Please circle your selection: phone call, email or text message

It is our policy to provide our patients with a detailed description of their prior authorization status and any out of pocket expenses prior to their arrival on procedure day. Please tell us your preferred method of contact regarding this type of correspondence.
Please circle your selection: mail or email

Signature of Patient or Personal Representative: _____ Date: _____
If Personal Representative, give relationship to patient: _____