

Scheer & Liesen Surgical Associates
20 Tower Court, Suite A Gurnee IL 60031
(847) 244-3525

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- ❖ *Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.*
- ❖ *Obtain payment from third-party payers.*
- ❖ *Conduct normal healthcare operations such as quality assessments and physician certifications.*

I have received, read and understand your **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I understand that Scheer & Liesen Surgical Associates has the right to change its **Notice of Privacy Practices** from time to time and that I may contact this office at any time at the address above to obtain a current copy of the **Notice of Privacy Practices**.

I understand that I may request in writing that you restrict how my private information 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 then you are bound to abide by such restrictions.

Patient Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their Protected Health Information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I, _____, hereby request Scheer & Liesen Surgical Associates to keep communication regarding my Protected Health Information confidential. To accomplish this request, please adhere to the following requests:

Communication Preference(s): ___ Letter ___ Cell ___ Home ___ Work

Phone: You can contact me by phone at _____ or _____
Leave messages on answering machine: ___ Yes ___ No

Can we send you e-mail reminders on appointments or account balances? ___ Yes ___ No

E-mail: You can contact me via e-mail @ _____

You may discuss my Protected Health Information with the following individuals:

Name _____	Relationship _____	Phone # _____
Name _____	Relationship _____	Phone # _____
Name _____	Relationship _____	Phone # _____

Other requests for Confidential Communications: _____

Patient Signature: _____ Date: _____

If you are not the patient, please specify your relationship to the patient: _____