Privacy Acknowledgment and General Consent

I understand that my privacy is protected and I have received a copy of the Privacy Policy		☐ Yes
I have been offered Advance Directive information (Not Applicable for Patients under 18 years old)		☐ Yes
I consent to receive medical care and treatment from Prima Medical Foundation		☐ Yes
I have read and understand the Office and Financial Policies. I understand that any violation of these terms is subject to referral to a collection agency and/or immediate dismissal.		☐ Yes
I give my physician and/or my physician representative permission to leave a confidential message for me at the following phone number:		Ph:
I give my physician and/or my physician representative permission to discuss my medical care with:	Name/Relationship:	Ph:

Prima Medical Foundation participates in the California Immunization Registry (CAIR), I understand my, or my child's, information will be included in that registry unless I choose not to participate.	☐ I choose to decline participation in CAIR.

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 this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below 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 that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Today's Date _____

Patient Name (Print) _____

Patient Date of Birth _____

Signature of Patient/Parent/Guardian _____

If patient is a minor, relationship to patient _____

For office use only
I attempted to obtain the patient's signature in acknowledgment of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date _____ Signature _____

Reason _____