

REGIONAL PHYSICIANS ORTHOPAEDICS

**404 Westwood Ave., Suite 205
High Point, NC 27262 (336) 884-1400**

Notice of Privacy Practices Receipt Acknowledgement

I have been presented with a copy of Regional Physicians Orthopaedics' Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law. I understand the contents of the notice.

Patient Name _____ Date of Birth _____ Signature of Patient or Guardian _____
Date _____

(1) Please list the family members and/or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment & health care operations):

Name _____ Phone Number _____

Name _____ Phone Number _____

Name _____ Phone Number _____

(2) Please list the family members and/or other persons, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY**:

Name _____ Phone Number _____

Name _____ Phone Number _____

Name _____ Phone Number _____

(3) Please list the telephone number(s) where you want to receive calls about your appointments, lab & x-ray results, or other health care information:

(4) Can confidential messages (i.e. appointment information) be left on your answering machine? _____ Yes _____ No

It is your responsibility to update this information as needed.

Internal Use Only

If patient or patient's representative refuses to sign acknowledgement of receipt of Notice, please document the date and time the Notice was presented to patient and sign below: Presented on (date) _____

Name/Title _____

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