

Brian D. Jackson, DPM, LLC

HIPPA Acknowledgement

TELEPHONE PERMISSION

Where do you prefer to receive calls:

- Home phone # _____ Mobile # _____
 Work phone # _____ Extension # _____

Messages:

I _____ agree to allow Dr. Brian Jackson / or a member of their staff to leave a message (please check all that are acceptable).

- On my answering machine.
 With _____ (specify name and relationship).
 Exclusively with me.

Regarding:

- An appointment Referrals
 Pending test results RX Information
 Billing information Other _____

This document will be considered valid unless a written revocation is received.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I, _____, hereby acknowledge receipt of the Notice of Privacy Practices given to me by Brian D. Jackson, DPM, LLC.

Signed: _____ Date: _____

FOR OFFICE ONLY:

If not signed, reason why acknowledgement was not obtained: _____

Person seeking acknowledgement: _____ Date: _____

FOR OFFICE USE ONLY:

HIPPA Privacy Policy:

Has the patient acknowledged receipt of Brian D. Jackson, DPM, LLC's Privacy Policy?
 Yes

Thank you for filing out this form completely. The information you have provided will help us serve your healthcare needs more effectively and efficiently.

New Patient Information

Updated Information Date Updated _____ Date Updated _____ Date Updated _____