115 North Main Street
Montgomery, Illinois 60538
Phone 630.801.8773
Fax 630.264.6734

Notice of Privacy Practices Acknowledgement (HIPPA)

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), 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 or indirectly.
- Obtain payment from third-party payers
- Conduct normal health care operations such as quality assessments and physician certifications

I acknowledge that I have received 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* and that I may contact this organization at any time at the address above to obtain a 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: _____

FOR OFFICE USE ONLY		
I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented:		
Date:	Initials:	Reason:

COMMUNICATION PREFERENCES:

We make every effort to make a reminder call the day before a patient appointment. There may be other times we need to call and the patient is not available. Please indicate which of the following are acceptable in the event we need to leave a message.

Can leave a message on answering machine on primary phone number? ☐ Yes ☐ No
Can leave a message with spouse/parent/child/roommate? ☐ Yes ☐ No
Can leave a message at work number (if applicable)? ☐ Yes ☐ No

When in the waiting room, do you prefer to be addressed as:
☐ First name: _____
☐ Last name: Mr./Mrs. _____

PERMISSION FOR RESIDENT / INTERN OBSERVATION:

Synergy participates in a learning program where, from time to time, students will be working with us to fulfill their obligations. Your signature below will allow a resident/intern/student to observe/participate in your treatment. You have the right to revoke this authorization

Please acknowledge by checking: ☐ Agree ☐ Disagree ☐ Observation Only

Signature: _____ Date: _____

PERMISSION TO PHOTOGRAPH:

Synergy is requesting your permission to photograph you / your dependent. This is strictly for your medical records and the evaluation of your health concerns and physical progress
☐ Yes, I give my permission for myself / my dependent's photograph. I understand that this authorization will be in effect until revoked in writing or by oral notification
☐ No, I do not give permission to photograph myself / my dependent

Signature: _____ Date: _____