Northeast Foot Care, PLLC
Dr. David Lambarski, DPM, FACFAS

Acknowledgement of Receipt of Privacy Notice

I understand that as part of my health care, Northeast Foot Care, PLLC, originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, as well as plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment;
- A means to facilitate communication among the many health care professionals who contribute to my care;
- A source of information for applying my diagnosis and surgical information to my bill;
- A means by which a third-party payer can verify that services billed were actually provided; and
- A tool for health care operations of Northeast Foot Care, PLLC such as assessing quality of care and reviewing the competence of health care professionals.

I understand that as part of Northeast Foot Care PLLC's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity for the purposes stated above.

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of how Northeast Foot Care PLLC may use and disclose my protected health care information. I further understand that Northeast Foot Care PLLC reserves the right to change its Notice of Privacy Practices. Should Northeast Foot Care PLLC change its Notice of Privacy Practices, an amended copy will be posted in a prominent location at the practice site, or, upon my request, an amended copy will be sent to the address I have provided.

I agree that Northeast Foot Care PLLC may do the following unless I specifically give direction prohibiting such activity:
- Send visit reminders and test results to the address that I have provided.
- Send routine correspondence, such as billing statements, to the address I have provided.
- Leave messages on an answering machine, voice mail, or email associated with the telephone numbers and email address I have provided to either confirm appointments or to request that I call the Practice on medical or billing matters.

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Patient's Signature or Signature of Personal Representative Date

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Office Use Only
Receipt received by ______________________________ on ________________________
Patient refused to sign receipt _________________________ (signature of Northeast Foot Care rep.)

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