Ankle & Foot Specialists of Puget Sound, PS

Name of Patient: _____

NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT

By my signature below I acknowledge that I have been provided a copy of the Notice of Privacy Practices and authorize the below information to be true.
(Copies are available at the front desk upon request.)

We will occasionally need to leave information regarding your healthcare. The information we may be contacting you for would be concerning **appointments, orthotics, surgery, insurance benefits,** etc. In regard to these:

May we leave a message on your home recorder/voicemail with specific information?

Authorized Phone Number(s): _____

Appointments? Yes_____ No_____

Orthotics? Yes_____ No_____

Surgery? Yes_____ No_____

Insurance Benefits? Yes_____ No_____

May we leave a message with people answering this number? Yes_____ No_____

If yes, is there someone specific to leave it with? Yes_____ No_____

Name(s) of authorized individual(s)_____

_____ _____
Patient or Authorized Individual Signature Date

_____ _____
Printed name of Above Signer Relationship