

COMPREHENSIVE ORTHOPAEDICS, S.C.

Patient Acknowledgement & Record of Disclosures

I, _____, acknowledge that I have received the written Notice of Privacy Practices
Patient Name
from Comprehensive Orthopaedics, S.C.

This form MUST be filled out NEATLY & COMPLETELY or it will be considered VOID.

Patient or Personal Representative Signature

Date

If Personal Representative, describe relationship

- The patient's condition prohibits the individual from signing an acknowledgement at this time. It will be obtained as reasonably practicable after the patient's condition improves.

I wish to be contacted in the following manner (check all that apply):

- Home Telephone: _____
 - Leave message with detailed information
 - Leave message with call back number only
- Work Telephone: _____
 - Leave message with detailed information
 - Leave message with call back number only
- Written Communication
 - Can mail to Home address
 - Can mail to Work address
 - Can fax to this number: _____

THE FOLLOWING INFORMATION IS REQUIRED FOR ALL PATIENTS

- I consent to have my personal health information disclosed to my:
 - Spouse: _____ Phone#: _____ D.O.B.: _____
 - Parent: _____ Phone#: _____ D.O.B.: _____
 - Parent: _____ Phone#: _____ D.O.B.: _____
 - Other: _____ Phone#: _____ D.O.B.: _____
 - Other: _____ Phone#: _____ D.O.B.: _____
- My personal health information should not be disclosed to any person other than myself.

Patient Signature

Date

Printed Name

Birth Date

RESERVED FOR OFFICE USE
WITNESS INITIALS: _____