North Texas Neurosurgical and Spine Center
1300 W. Terrell Ave # 300 Fort Worth, Texas 76104 P 817.820.4280 F 817.820.4281

NOTICES OF PRIVACY PRACTICES ACKNOWLDGEMENT

I understand that under the Health Insurance Portability and Privacy Act of 1996 (HIPAA), I have certain rights to privacy and confidentiality concerning my medical records and patient care and other Protected Health Information (PHI).
I understand this information can and will be used to:

- Conduct, plan, and direct my diagnosis, treatment and follow-up among multiple providers and services who may be involve in my care
- Obtain payment from third party payors other than yourself
- Conduct normal healthcare operational concerns such as quality assessments and physicians certifications

I have received, read, reviewed and understand your Notice of Privacy Practices contain a more complete and detailed description of the uses and disclosures of my health information. I understand our practice and staff have a right to change this privacy practice from time-to-time and that I may contact their Compliance Officer at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

PATIENT NAME: _____DOB:_____
Do we have permission to?

- Leave a message on your home answering machine regarding appointments? Y N
- Leave a message on you home answering machine asking you to call our office? Y N
- Contact you at your place of employment? Y N
- Discuss or coordinate your care plan with other providers including , but not limited to, physical therapist, home health, nursing homes, assisted living homes Y N

List names below that we can contact concerning your care and medical condition:

NAME	RELATIONSHIP	PHONE
_____	_____	_____
_____	_____	_____
_____	_____	_____

ADDTIONAL COMMENTS:

PATIENT SIGNATURE
DATE

OFFICE USE ONLY:
I attempted to obtain the patient authorization for HIPAA and was unable to because:

Signature
Date