Dr. Zina B. Cappiello DPM LLC

HIPAA Consent Form and Privacy Practice Acknowledgement

I,_____, understand that under the Health Portability and Accountability Act 1996 (HIPAA) I have certain rights to privacy regarding my health information. I also understand that Dr. B. Cappiello DPM, LLC originates and maintains paper and/or electronic records describing my health history, symptoms, examinations, test results, diagnoses, treatments and any plans for future care and treatment at Dr. Zina B. Cappiello DPM, LLC. I understand that this information can be used as:

A basis for planning my care and treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.

A means of communication among the many health professionals who contribute to my care.

A means by which a third-party payer can verify that services billed were actually provided and obtain payment from third party payers.

A tool for routine healthcare operations such as assessing quality and receiving the competence of healthcare professionals.

I prefer to have notification of my healthcare information by the following methods. Please check all applicable:

_____ Home telephone
_____ If I am not available, you may leave a message with a family member
_____ Detailed message on answering machine
_____ Work phone with direct contact only
_____ Cell phone

My health information may also be discussed with the following people upon their request:

Name: _____ Relationship: _____

_____ _____

_____ _____

Patient Signature Date

ACKNOWLEDGEMENT OF RECEIPT
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided an opportunity to read (if I chose to), a copy of the notice of Privacy Practices and understood the notice.

_____ _____

Patient Name (please print) Date

Parent of Authorized Representative (if applicable) Signature_____