835 7th St Suite 5,Clermont FL 34711

Acknowledgement of Notice of Privacy Practices

Health Insurance Portability and Accountability Act of 1996(HIPAA)

I hereby acknowledge that I received Orange Doc Family Medicine, PLLC Notice of Privacy Practices.

*Print Name:___________________________ *SS#:_______________________
Social Security Number

*____
SIGNATURE OF PATIENT OR PATIENT REPRESENTITIVE

Your Phone Number:____

Emergency Contact Information

Name:________________________ Relationship ________________________ Phone( )_________________________

What is your insurance preferred laboratory:____

Documentation of Good Faith Efforts
To obtain patient's acknowledgement that they received provider's
Notice of Privacy Practices

(**For use when acknowledgement cannot be obtained from the patient**):

The patient presented on __________ and was provided with a copy of Covered Entity's Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgement of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

Patient Refused to sign____________

Patient was unable to sign or initial because____

The patient had a medical emergency, and an attempt to obtain the acknowledgement will be made at the next available opportunity.____

____ Date____________
** Signature of Employee Witnessing Signature

REFILLS:

Our office DOES NOT prescribe or refill long term narcotic pain medications for any reason. If you require long term use of a narcotic pain medication as part of your treatment, you should have these medications managed by a specialist in narcotic pain management.

*For all other Medication Refills, please notify our office at least two (2) business days in advance.

***Signature of Patient:____________________________________ Date____________________________**