Receipt of *Notice of Privacy Policy* & Consent Form

Plymouth Podiatry
116 Court Street, 2nd Floor
Plymouth, MA 02360

Patients Name:_____

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you and obtain payment for our services and to conduct healthcare operations involving our office.

The Notice of Privacy Practices you have been given describes these and uses disclosures in detail. You are free to refer to this notice at any time before you sign. As described in our ***Notice of Privacy Practices,*** the use and disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payments include but not limited to; (1) Our submission of your health information to a billing agent or vendor for processing claims or obtaining payment. (2) Our submission of claims to third-party payers of insurers for claims review, determination of benefits and payments. (3) Our submission of your health information to auditors hired by third-party payers. (4) Other aspects of payments described in our ***Notice of Privacy Practices***. Our ***Notice of Privacy Practices*** will be updated whenever our privacy practices change. You can get an update copy here at the office.

By signing this consent document you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payments for our services and to perform healthcare operations. You also signify that you have received a copy of our ***Notice of Privacy Practices.***

You have the right to ask us to assist the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our ***Notice of Privacy Practices***, we are not obliged to agree to these suggested restrictions. If we do agree however, the restrictions are binding on us. Our ***Notice of Privacy Practices*** describes how to ask for restriction.

I have read this document and understand it. I consent to the use and disclosure of my health information for the purpose of treatment, payment, and healthcare operations. I acknowledge that I have received the ***Notice of Privacy Practices.***

_____ _____

Signature **Date**

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form.

_____ _____

Relationship to patient **Print Name**

Source of authority: (i.e power of attorney, guardianship, etc.)