AESTHETIC ASSOCIATES, INC., P.S.
WILLIAM A. PORTUESE, M.D.

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

MY SIGNATURE CONFIRMS THAT I HAVE BEEN INFORMED OF MY RIGHTS TO PRIVACY REGARDING MY PROTECTED HEALTH INFORMATION, UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA). I UNDERSTAND THAT THIS INFORMATION CAN AND WILL BE USED TO:

- PROVIDE AND COORDINATE MY TREATMENT AMONG A NUMBER OF HEALTH CARE PROVIDERS WHO MAY BE INVOLVED IN THAT TREATMENT DIRECTLY AND INDIRECTLY
- OBTAIN PAYMENT FROM THIRD-PARTY PAYERS FOR MY HEALTH CARE SERVICES
- CONDUCT NORMAL HEALTH CARE OPERATIONS SUCH AS QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES

I HAVE BEEN INFORMED OF MY MEDICAL PROVIDER'S *NOTICE OF PRIVACY PRACTICES* CONTAINING A MORE COMPLETE DESCRIPTION OF THESE USES AND DISCLOSURES OF MY PROTECTED HEALTH INFORMATION. I HAVE BEEN GIVE THE RIGHTS TO REVIEW AND RECEIVE A COPY OF SUCH *NOTICE OF PRIVACY PRACTICES* AND THAT I MAY CONTACT THIS OFFICE AT THE ADDRESS BELOW TO OBTAIN A CURRENT COPY OF THE *NOTICE OF PRIVACY PRACTICES.*

I UNDERSTAND THAT I MAY REQUEST IN WRITING THAT YOU RESTRICT HOW MY PRIVATE INFORMATION IS USED OF DISCLOSED TO CARRY OUT TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS AND I UNDERSTAND THAT YOU ARE NOT REQUIRED TO AGREE TO MY REQUESTED RESTRICTIONS, BUT IF YOU DO AGREE THEN YOU ARE BOUND TO ABIDE BY SUCH RESTRICTIONS.

PATIENT NAME (PRINT) _____ DATE _____

PATIENT SIGNATURE _____

RELATIONSHIP TO PATIENT _____

OTHER INDIVIDUALS WITH WHOM WE MAY DISCUSS YOUR HEALTHCARE:

_____ _____

PLEASE PROVIDE ONE PHONE NUMBER YOU CHECK FREQUENTLY THAT WE MAY LEAVE MESSAGES ON.

( ) _____

FOR OFFICE USE ONLY:

WE WERE UNABLE TO OBTAIN THE PATIENT'S WRITTEN ACKNOWLEDGEMENT OF OUR NOTICE OF PRIVACY PRACTICES DUE TO THE FOLLOWING REASON:

☐THE PATIENT REFUSED TO SIGN ☐COMMUNICATION BARRIERS ☐EMERGENCY SITUATION ☐OTHER