



Privacy Acknowledgment and General Consent

I understand that my privacy is protected and I have received a copy of the Privacy Policy	<input type="checkbox"/> Yes
I have been offered Advance Directive information (Not Applicable for Patients under 18 years old)	<input type="checkbox"/> Yes
I consent to receive medical care and treatment from Prima Medical Foundation	<input type="checkbox"/> Yes
I have read and understand the Office and Financial Policies. I understand that any violation of these terms is subject to referral to a collection agency and/or immediate dismissal.	<input type="checkbox"/> Yes
I give my physician and/or my physician representative permission to leave a confidential message for me at the following phone number:	Ph:
I give my physician and/or my physician representative permission to discuss my medical care with:	Name/Relationship: Ph:

Prima Medical Foundation participates in the California Immunization Registry (CAIR), I understand my, or my child's, information will be included in that registry unless I choose not to participate.	<input type="checkbox"/> I choose to decline participation in CAIR.
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I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time 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 or disclosed to carry out treatment, payment or health care operations. I also 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.

Today's Date

Patient Name (Print)

Patient Date of Birth

Signature of Patient/Parent/Guardian

If patient is a minor, relationship to patient

For office use only

I attempted to obtain the patient's signature in acknowledgment of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date _____ Signature _____

Reason _____