



PATIENT NAME: _____

(Please Print)

**ENT of Georgia, LLC
Privacy Policy Acknowledgement Statement**

I hereby acknowledge that I have been made aware that ENT of Georgia has a Privacy Policy in place in accordance with the Health Insurance Portability and Accountability ACT of 1996(HIPAA).

As a patient of ENT of Georgia, I understand and acknowledge the following:

1. ENT of Georgia has a privacy policy in effect in their office.
2. ENT of Georgia has made this policy available to me for review, by placing a complete version in a binder that resides in the waiting room, and/or by placing a poster of this policy in the waiting room or similar common area with patient access.
3. ENT of Georgia has made me aware, that as a patient, I am entitled to a copy of this privacy policy if I desire a copy for my personal file.

Upon review of the above statements, please sign below acknowledging that you have been advised of the privacy policy implemented by ENT of Georgia and have read and understood the acknowledgement form,. If you desire a copy of the Privacy Policy, please request one at this time.

___ No, I do not want a copy, but acknowledge the Privacy Policy exists.

___ Yes, I do want a copy of the Privacy Policy

Patient Signature (Guardian if patient is a minor)

Patient Agreement for Communication

I understand that as part of my healthcare, ENT of Georgia will need to contact me in order to remind me of an appointment, provide test results, give instructions, or provide other information.

I authorize ENT of Georgia to contact me in the following ways (check those which you authorize):

- | | |
|----------------------|----------------------|
| ___ Home phone ----- | ___ Voicemail OK |
| ___ Work phone ----- | ___ Voicemail OK |
| ___ Cell phone ----- | ___ Voicemail OK |
| ___ Fax | ___ Text OK |
| ___ E-Mail | Email Address: _____ |

ENT of Georgia does not use secure server for e-mail communication. Because a secure server is required by law for e-mail communication with patients, ENT of Georgia does not endorse the use of email communication with patients.

I understand that ENT of Georgia will use the minimum necessary information needed when communicating with me indirectly. I understand that I may revoke or modify this agreement at any time. Any revocation or change will not apply to past communications.

I further authorize ENT of Georgia to discuss matters related to my condition/care with the following:

(Please Print)

Relationship to patient

(Please Print)

Relationship to patient

Signature (Guardian if patient in a minor)

Date