SOUTHERN SURGICAL

ACKNOWLEDGEMENT OF RECEIPT OF

HIPAA NOTIFICATION

Signature below is acknowledgement that you have been given and had the opportunity to read our Notice of Privacy Practices. Should you wish to read the Notice at any other time, please request upon the arrival of your office visit. Any questions concerning our policy should be directed to our staff for clarification. It is our policy to provide this Notice at your first visit, and you may obtain another copy at any subsequent visit. This acknowledgement and authorization remains in effect until we are notified, in writing, by you of any changes.

Print Name______________________________Date______________________________

Signature______________________________DOB______________________________

Please list all additional authorized persons with whom we may discuss any of your medical information (this includes scheduled appointments).:

1.________________________ 3.________________________ 5.____________________

2.________________________ 4.________________________ 6.____________________

LABORATORY PROCEDURES

This clinic may utilize an outside laboratory to process lab-related services that cannot be performed in our office. In that case, you and/or your insurance company will receive a bill from the outside laboratory for your lab work.

To avoid out-of-network charges, which will result in additional cost to you, please let your physician or nurse know immediately if your health insurance policy requires us to send your lab work to another lab. Patients or guardians are responsible for communicating this insurance requirement to our staff at each appointment.

I have read and understand the above two Notices. I also understand that I will be responsible for all charges incurred related to out-of-network services.

Patient Name (please print)________________________Date______________

Patient/Guardian Signature____