

Notice of Privacy Practices Acknowledgement Form Fee Schedule, Email and X-Ray Consent

THE NOTICE OF PRIVACY PRACTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY, AS IT EXPLAINS:

- How this office will use and disclose your protected health information.
- Your privacy rights with regard to your protected health information.
- This office's obligations concerning the use and disclosure of your protected health information.

THE FEE SCHEDULE IS TO BE SURE THAT YOU ARE FULLY INFORMED ABOUT OUR FEES AND PAYMENT POLICIES AS IT EXPLAINS

- The type of services we provide and the fees for those services.
- The insurance and forms of payment we accept.

EMAIL CONSENT

- Email communication with West LA Hand Center is provided as a convenience to the patient; however, by your continued communication via email with West LA Hand Center, you consent to email communication and are accepting the inherent insecurity and the privacy risks therein.

X-RAY CONSENT – FEMALE PATIENTS

- If you are pregnant or think you possibly may be, please inform us prior to your x-ray examination.

I acknowledge that I have received a copy of the office Notice of Privacy Practices, Fee Schedule and Email Consent. I further acknowledge that the office Notice of Privacy Practices and Fee Schedule is available at the front desk upon request.

Patient or Patient Representative Signature

Date

Patient or Patient Representative Printed Name