Dayton Arthritis & Allergy Center
3075 Governor's Place Blvd
Suite 110
Dayton, OH 45409
(937) 296-0015

Patient Name: ______________________________

Please answer the following questions so that we may contact you in the most effective way possible.

1. If we call you at home and you are not available, may we leave positive/negative test results, appointments, billing matters or health care operations with another person? **YES NO**
2. If yes, please state name of person(s) and relationship:

   Name: ____________________________ Relationship____________________________

   Name: ____________________________ Relationship____________________________

   Name: ____________________________ Relationship____________________________
3. Do you have an answering machine at your home? **YES NO**
4. If yes, may we leave a message regarding positive/negative test results, appointments, billing matters, or health care operations? **YES NO**
5. Do you have voice mail through your employer? **YES NO**
6. If yes, may we leave a message for you to return our call? **YES NO**
7. May we send you correspondence in our business envelopes? **YES NO**
8. May we send you messages through your email or patient portal? **YES NO**

Authorization is valid until you inform our office in writing of any changes.

Patient Signature: ____ Date____________________
(Guardian if under age 18)

Employee Signature: ____________________________________ Date____________________

- If above answers are NO, how is the best way to contact you? ____________________
  ____
- I am fully aware that a cellular telephone is not a secure and private line

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Notice of Privacy Practices Acknowledgement

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 health care 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 acknowledge that I have received 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 above 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 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: ______________________________

Relationship to Patient: ______________________________

Signature: ______________________________

Date: ______________________________

Office Use Only

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

Date: ______________________________

Employee: ______________________________

Reason: ______________________________