Weatherford Podiatry Clinics, P.A.
Waymon E. Lewis, Jr., DPM
224 Santa Fe, Suite 300
Weatherford, Texas 76086

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the **Health Insurance Portability and Accountability Act of 1996** (HIPPA), I have certain right 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 acknowledge that I have received you ***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 this ***Notice of Privacy Practices*** from time to time and that I may contact this organization at any time at the above address 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 to be used or disclosed to carry out treatment, payment, or healthcare options. I also understand that you are not required to request restrictions, but if you do agree, then you are bound to abide by such restrictions.

PATIENT NAME: _____

Relationship to patient: _____

Signature: _____ Date:_____

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

Date:_____ Initials: _____

Reason: _____

Adapted April 14, 2003 (HIPPA Privacy)