Charles C. Greene, MD, PhD www.jacksonvilleENTsurgery.com

MAIN OFFICE	SATELLITE OFFICE	SATELLITE OFFICE	SATELLITE OFFICE	SATELLITE OFFICE
11512 Lake Mead Ave Ste #536	4131 University Blvd S #18	3890 Dunn Ave Ste #202	6484 Ft Caroline Rd	789 W. Duval St
Jacksonville, FL 32256	Jacksonville, FL 32216	Jacksonville, FL 32218	Jacksonville, FL 32277	Lake City, FL 32055
(904) 419-2054 (Ph)	(904) 419-2054 (Ph)	(904) 419-2054 (Ph)	(904) 419-2054 (Ph)	(904) 419-2054 (Ph)
(904) 419-2057 (Fax)	(904) 419-2057 (Fax)	(904) 419-2057 (Fax)	(904) 419-2057 (Fax)	(904) 419-2057 (Fax)

PATIENT PRIVACY PRACTICE ACKNOWLEDGEMENT AND CONSENT

I understand that, under the Health Insurance Portability and 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 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 physicians certifications.

I have read and understand 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 to obtain a current copy of the Notice of Privacy Practices.

I have reviewed and I consent to the above statements.

Patient Name:_____ Phone: (_____)_____-_____

Patient/Guardian Signature:_____ Date:_____

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PATIENT CONTACT

All calls regarding your appointments, diagnostic or surgical scheduling will be made to your home phone number. If you would like us to contact you on an alternate phone number, please indicate that number here:_____ Location:_____

_____ I hereby authorize this medical practice to contact me by telephone and if I am not present, they may
(initial here) leave a message on my answering machine/voicemail or with (name of individual):_____

~OR~

_____ If you prefer that we do **NOT** leave messages on your answering machine.
(initial here)

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OFFICE USE ONLY

Signed form received by *(print):*_____Initials: _____

Acknowledgement refused:_____

Reason for refusal:_____