AOSMI
ADVANCED ORTHOPEDICS AND SPORTS MEDICINE INSTITUTE
A center of excellence for bone and joint care

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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 by AOSMI to: conduct, plan, and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment, directly or indirectly; obtain payment from Medicare and third-party payers; and conduct normal healthcare operations such as quality assessments and physician certifications.

I have read and understand AOSMI's HIPAA Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information. I understand that AOSMI has the right to change its HIPAA Notice of Privacy Practices from time to time and that whenever an important change is made, AOSMI will post a new notice in the office. I may contact AOSMI at any time at the address below to obtain a current copy of the HIPAA Notice of Privacy Practices. I agree that Advanced Orthopedics and Sports Medicine Institute may request my prescription medication history from pharmacies for treatment purposes.

DESIGNATION OF DISCLOSURE

I agree that AOSMI may disclose my protected health information to a family member, close personal friend, or other caregiver, since such person is involved with my healthcare and/or payment relating to my healthcare. In that case, AOSMI will disclose only information that is directly relevant to the person's involvement with my healthcare and/or payment relating to my healthcare, unless I request otherwise. I understand that for uses and disclosures to individuals or entities that require an authorization pursuant to HIPAA, AOSMI will provide me with a HIPAA-compliant authorization form for my completion.

I designate the following persons listed below as a person or persons involved with my healthcare and/or payment:

Name:_____ Relationship:_____ Health Info: Yes / No Payment Info: Yes / No (circle one)

Name:_____ Relationship:_____ Health Info: Yes / No Payment Info: Yes / No (circle one)

Name:_____ Relationship:_____ Health Info: Yes / No Payment Info: Yes / No (circle one)

Emergency Contact:_____ **Number:**_____ **Relationship:**_____

CONTACT INFORMATION

I wish to be contacted in the following manner (Please check all that apply):

☐ Home Telephone	☐ Detailed Message	☐ Call Back Number Only	☐ Billing Information Allowed
☐ Work Telephone	☐ Detailed Message	☐ Call Back Number Only	☐ Billing Information Allowed
☐ Cell	☐ Detailed Message	☐ Call Back Number Only	☐ Billing Information Allowed
☐ Mail to Home Address	☐ Mail to Work Address		

Acknowledgement and Agreement to the terms and conditions of this document:

Patient's Name:_____ Date:_____

Signature:_____ Printed Name:_____
(Patient/Parent/Guardian) (Patient/Parent/Guardian)

301 PROFESSIONAL VIEW DRIVE * FREEHOLD, NJ 07728 * PHONE: 732-720-2555 * FAX: 732-720-2556
312 APPLEGARTH ROAD * MONROE TOWNSHIP, NJ 08831 * PHONE: 609-235-4100 * FAX: 732-720-2556
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