ORTHOSPORTS ASSOCIATES, L.L.C.

Receipt for HIPAA Privacy Notice and Specification of Communication Methods

Patient Name: _____ Patient Date of Birth: _____ Account Number: _____

Patient Contact Information: I hereby request that communication from OrthoSports Associates, L.L.C. ("OrthoSports") concerning the above-named patient be transmitted using the following contact methods and contact information. (*If any contact method is not desired, please leave blank*).

Telephone Number: _____ Physical Address: _____
E-Mail Address: _____

Emergency Contact Information: In the event of a medical emergency or if I am otherwise unavailable, I hereby allow OrthoSports to discuss billing, appointments, treatment, diagnosis, test results, and other protected health information regarding the patient with the following persons who are involved with the patient's health care and/or payment related to the patient's health care:

Name: _____
Telephone Number: _____
Relationship to Patient: _____

Name: _____
Telephone Number: _____
Relationship to Patient: _____

Yes	No	*(Please check one)*
☐	☐	OrthoSports may confirm appointments and may leave lab results or other diagnostic testing results (*e.g.*, MRI, CT, bone scan, etc.) on my answering machine using the telephone number provided above.
☐	☐	OrthoSports may release information to the following pharmacy without prior patient authorization in order to transmit a prescription. Pharmacy Name _____ Pharmacy Telephone Number: _____ Pharmacy Street Address: _____
☐	☐	OrthoSports (or its representatives) may send me e-mails regarding appointment reminders and practice forms to the e-mail address listed above. (Communications containing copies of medical records, details regarding the patient's treatment and diagnosis, and test results will not be made via e-mail unless I have completed the separate E-Mail Consent Form.) By agreeing to receipt of e-mail communications, I understand that there are risks associated with using e-mail as a means of communication, including, but not limited to the following: e-mail can be circulated, forwarded, and stored in numerous paper and electronic files without my knowledge; e-mail can be sent immediately worldwide and received by large numbers of unintended individuals; e-mail can be misaddressed causing the information to be sent to the wrong person; and e-mail can be intercepted, changed, and redistributed to others. Because of these and other risks, I understand that OrthoSports cannot guarantee the security and confidentiality of e-mail communications, and will not be responsible for improper disclosures as a result. OrthoSports will, however, attempt to use reasonable means to protect the security and confidentiality of e-mail sent and received.
☐	☐	OrthoSports (or its representatives) may use any telephone number or other contact information provided to OrthoSports, including but not limited to a cellular number or e-mail address, to contact me regarding the patient's care and accounts. Methods of contact by OrthoSports (or its representatives) may include telephone calls, texts, e-mails, pre-recorded messages or automated dialer. (Communications containing copies of medical records, details regarding the patient's treatment and diagnosis, and test results will not be made via e-mail unless I have completed the separate E-Mail Consent Form.)
☐	☐	OrthoSports is required to provide timely online access to a patient's health information. However, participation is voluntary. By checking "yes," you are indicating that you are interested in obtaining online access to the patient's health information. If you check "yes", you should receive an e-mail in approximately four (4) business days providing instructions on how to access the online information. By checking "no" you are indicating that you are not interested in obtaining online access to the patient's health information. However, you can change your mind at any time by notifying OrthoSports.

My signature below is acknowledgment that I have received a copy of the OrthoSports Privacy Notice and that I agree to the conditions stated in the Privacy Notice and the statements contained in this form.

Signature of Patient or Patient's Representative: _____ Date: _____

Printed Name of Patient's Representative (*if applicable*): _____ Relationship to Patient: _____