**CASANOVA EYE CARE, APMC**

**Robert T. Casanova, Jr., M.D.**

**1110 Dr. A.C. Terrence BLVD., Suite 1**

**Opelousas, La 70570**

**(337) 942-3449**

**HIPAA PATIENT ACKNOWLEDGEMENT**

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

You may refuse to sign this acknowledgement but, in refusing we will not be allowed to process your insurance claims.

Date:\_\_\_\_\_\_\_\_\_\_\_\_

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for **CASANOVA EYE CARE, APMC**. A copy of this signed, dated acknowledgement shall be as effective as the original. **MY SIGNATURE WILL ASLO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHERS BE SENT TO OTHER ATTENDING DOCTORS IN THE FUTURE.**

-A copy of Notice of Privacy Practice is located in our front lobby-

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Please **print** your name Please **sign** your name

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Legal Representative Description of Authority

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTHCARE INFORMATION:

(This includes any care takers who can have access to patient’s records):

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(If no one is listed above, initial here:\_\_\_\_\_\_)**

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY HEALTHCARE APPOINMENTS, TREATMENT, AND BILLING INFORMATION VIA:**

○ Cell Phone Confirmation

○ Home Phone Confirmation

○ Work Phone Confirmation

○ U.S. Mail/Postcard

○ Any of the Above

I AUTHORIZE **INFORMATION ABOUT MY HEALTHCARE BE CENVEYED VIA:**

○ Message on Cell Phone

○ Message on Home Phone

○ Message on Work Phone

○ U.S. Mail/Postcard

○ Any of the Above

**PLEASE NOTIFY OUR OFFICE IF YOU ARE CURRENTLY RECEIVING HOSPICE CARE:**

\_\_\_\_\_\_Yes, I am receiving Hospice Care \_\_\_\_\_\_No, I am not currently receiving Hospice Care