Summary of Private Practices

We are required by federal law (HIPAA) to provide a notice of Privacy Practices that describes how health information that we maintain about you may be used or disclosed. This summary describes how your protected health information may be used or disclosed and how you may gain access to this information. Please review this summary carefully. A complete copy of these policies is available for review in our waiting room, please ask the doctor for assistance if this summary is not available to you.

I have received the summary of Private Practices from Dr. Anne Jacobs and I understand that by signing this document I acknowledge and agree with these privacy practices.

Patient Signature:_____Date:_____

By signing below I give permission to Dr. Anne Jacobs to communicate with me via e-mail or fax. I acknowledge the inherent privacy risks associated with electronic communication.

E-mail:_____Fax Number:_____

Patient Signature:_____Date:_____

I give permission for messages to be left on my voicemail or answering machine.

Phone number(s) to leave messages on:_____

I give permission for the office of Dr. Jacobs to bill insurance on my behalf if appropriate.

Patient Signature:_____Date:_____

Patient's full name:_____
(please print)

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