PATIENT NAME:_____
(Please Print)

ENT of Georgia, LLC
Privacy Policy Acknowledgement Statement

I hereby acknowledge that I have been made aware that ENT of Georgia has a Privacy Policy in place in accordance with the Health Insurance Portability and Accountability ACT of 1996(HIPAA).

As a patient of ENT of Georgia, I understand and acknowledge the following:
1. ENT of Georgia has a privacy policy in effect in their office.
2. ENT of Georgia has made this policy available to me for review, by placing a complete version in a binder that resides in the waiting room, and/or by placing a poster of this policy in the waiting room or similar common area with patient access.
3. ENT of Georgia has made me aware, that as a patient, I am entitled to a copy of this privacy policy if I desire a copy for my personal file.

Upon review of the above statements, please sign below acknowledging that you have been advised of the privacy policy implemented by ENT of Georgia and have read and understood the acknowledgement form,. If you desire a copy of the Privacy Policy, please request one at this time.

___ No, I do not want a copy, but acknowledge the Privacy Policy exists.
___ Yes, I do want a copy of the Privacy Policy

_____
Patient Signature (Guardian if patient is a minor)

Patient Agreement for Communication

I understand that as part of my healthcare, ENT of Georgia will need to contact me in order to remind me of an appointment, provide test results, give instructions, or provide other information.

I authorize ENT of Georgia to contact me in the following ways (check those which you authorize):

_____ Home phone ----------	_____Voicemail OK
_____ Work phone ----------	_____ Voicemail OK
_____Cell phone ----------	_____Voicemail OK
_____Fax	_____ Text OK
_____E-Mail	Email Address: _____

ENT of Georgia does not use secure server for e-mail communication. Because a secure server is required by law for e-mail communication with patients, ENT of Georgia does not endorse the use of email communication with patients.

I understand that ENT of Georgia will use the minimum necessary information needed when communicating with me indirectly. I understand that I may revoke or modify this agreement at any time. Any revocation or change will not apply to past communications.

I further authorize ENT of Georgia to discuss matters related to my condition/care with the following:

_____	_____
(Please Print)	Relationship to patient
_____	_____
(Please Print)	Relationship to patient
_____	_____
Patient Signature (Guardian if patient is a minor)	Date