Notice Of Privacy Practices Receipt

I acknowledge that a Notice of Privacy Practices of University Orthopaedic Associates is posted on the UOA website and available to me upon my request.

Print name of patient: _____ Date: _____

Signature of patient: _____ SSN: _____

For personal representative of the patient (if applicable):

Print name of personal representative: _____ Date: _____

Signature of personal representative: _____ Relationship to patient: _____

For practice use only:

Signature of practice employee: _____ Date: _____

Please provide the following information:

(The following is an authorization for miscellaneous services this office uses. We will make every effort to abide by your instructions.)

Appointment Reminders/Test Results (laboratory, x-rays, etc.):

If we need to reach you regarding an appointment or test results, we will make every effort to reach you personally. If we cannot reach you personally, we will only leave a message asking you to call our office during regular business hours.

Please complete/check all items below that apply to you:

May we call/text/email to remind you of an appointment or regarding test results? ◯ Yes ◯ No

Please contact me:

Home Phone: _____ Cell Phone: _____

Email: _____ Work Phone: _____

If we get an answering machine/voicemail, may we leave a message? ◯ Yes ◯ No

If we get a family member, may we leave a message? ◯ Yes ◯ No

I understand I have a right to request communication with UOA, a division of OrthoNJ through email and by doing so I understand that currently their email is not encrypted. I also understand that non-encrypted email can result in possible public access of my personal information. My initials indicated below show I understand and still will like this type of communication to be possible.

Initials: _____ Date: _____

Policy for discussing your medical information with family members:

Our office will never discuss your medical information with a family member unless you have authorized us to do so. Please indicate the family members authorized to discuss your medical care by checking all items that apply to you and providing the name(s) where applicable.

Spouse ☐ _____

Parent(s) ☐ _____

Child(ren) ☐ _____

Sibling(s) ☐ _____

Other(s) ☐ _____