

# Loudoun Foot and Ankle Center (L.F.A.C.)

Mark D. Dollard DPM  
46440 Benedict Dr. Suite 111  
Sterling, VA 20164

## Notice of Privacy Practice Acknowledgement

I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- 1) Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- 2) Obtain payment from third party payers.
- 3) Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been provided the opportunity to review the *Notice of Privacy Practices* adopted by Loudoun Foot and Ankle Center containing a more complete description of the uses and disclosures of my health information. I understand that Loudoun Foot and Ankle Center has the right to change its *Notice of Privacy Practices* from time to time and that I may contact Loudoun Foot and Ankle Center at any time during normal business hours at the address below to obtain a current copy of the *Notice of Privacy Practice*.

I understand that I may request in writing that Loudoun Foot and Ankle Center restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that Loudoun Foot and Ankle Center is not required to agree to my requested restrictions, but if Loudoun Foot and Ankle center does agree then the Loudoun Foot and Ankle Center is bound to abide by such restrictions.

I **Do not** authorize L.F.A.C to discuss my billing/medical information with any other individual.

I authorize L.F.A.C to discuss my billing/medical information with my **Spouse** or **Guardian**.

I authorize L.F.A.C. to discuss my billing/medical information with immediate members of my family

I authorize L.F.A.C. to discuss my billing or medical information with the following individuals;

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

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

**Patient Name :** \_\_\_\_\_

**Guardian or Responsible Party** \_\_\_\_\_ **Relationship** \_\_\_\_\_

**\*Signature\*** \_\_\_\_\_

**Date:** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

**\*I have been provided with the opportunity to obtain a copy of this acknowledgement (Initials):** \_\_\_\_\_

### OFFICE USE ONLY

Loudoun Foot and Ankle Center attempted to obtain the patient's signature in acknowledgement on this *Notice of Privacy Practices Acknowledgement* but was unable to do so as documented for reasons below:

Date:	Initials	Reason:
-------	----------	---------