naba
Northeastern Association
of the Blind at Albany

Acknowledgement of Receipt of Privacy Policy

I understand that NABA's Notice or Privacy Practices describes the types or uses and disclosures of my protected health information that may occur in my treatment including referrals, payment of my bills, internal marketing, and/or in the performance of the health care operations of NABA. Our Notice of Privacy Practices explains our use and disclosure of your Protected Health Information. This notice has been mailed to you with your other paperwork or is available upon request at NABA. I acknowledge that I can receive a copy of this notice upon request.

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that NABA has acted in reliance upon this authorization. My written revocation must be submitted to NABA's Office Manager.

Name: _____ DOB:_____

DISCLOSURES: Exam Date: _____

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I allow NABA to leave information on the devices indicated below – please check any boxes you agree to:

LEAVE APPOINTMENT INFORMATION:

On Personal Voicemail? [ ]
Via Email? [ ]
On Office Voicemail? [ ]
Via Mail? [ ]
With Another Person? [ ]

LEAVE MEDICAL INFORMATION:

On Personal Voicemail? [ ]
Via Email? [ ]
On Office Voicemail? [ ]
Via Mail? [ ]
With Another Person? [ ]

Please list all Person or Persons Authorized to Communicate with NABA regarding (but not limited to) your Appointment Information, Medical Information and/or Billing Information:

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Please understand that NABA will not be able to release any information about your medical condition to anyone not authorized by you. It is your responsibility to change and/or update this information as necessary.

Print name: _____

Signature: _____

Date: _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient: _____

Source of Authority: _____

Print Name: _____

Signature: _____

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PATIENT FINANCIAL RESPONSIBILITY POLICY

I understand that NABA will be billing my insurance company. I also understand that it is my responsibility to read and understand my insurance coverage. If, for any reason, my insurance company does not pay NABA for services provided, I agree to pay NABA in full for all services rendered.

Print Name: _____

Signature: _____

Date: _____