Arleta Foot Care, Inc.
Abid Chaudhry, D.P.M., F.A.C.F.A.S.
9068 Woodman Ave.
Arleta, Ca 91331
(818) 892-3196

I understand that under Health Insurance Portability & 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 for the following:

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

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that Arleta Foot Care, Inc. has the right to change its *Notice of Privacy Practices* from time to time and that I may contact Arleta Foot Care, Inc. at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that Arleta Foot Care, Inc. restrict how my private information is used or disclosed to carry out treatment, payment and/ or health care operations. I also understand Arleta Foot Care, Inc. is not required to agree to my requested restrictions, but if Arleta Foot Care, Inc. does agree then Arleta Foot Care, Inc. will abide by such restrictions.

Print Name/ Escribir Nombre: _____

Patient Signature/ Firma del Paciente: _____

Relationship to Patient/ Relacion al Paciente: ☐ Self ☐ Misma/o ☐ Parent ☐ Other: _____

Date / Fecha: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this *Notice of Privacy Practices* acknowledgement form, but was unable to do so as documented below:

☐ Refused to sign Reason:_____

Date: _____ Staff Initials: _____