Frank W. Shagets M.D.
620 W. 32nd Street, Suite B
Joplin, Missouri 64804
Office Phone (417) 623 - 5111

Notice of Privacy Practices Acknowledgement Form

In the course of providing service to you, we create, receive and store health information about you. It is often necessary to use and share your health information with others to ensure you receive the appropriate medical treatment, receive payment and perform administrative tasks in our office such as filing insurance claims on your behalf.

The **Notice of Privacy Practices** you have been given describes these uses and disclosures in detail. As described in our **Notice of Privacy Practices,** the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also as may be necessary for you to receive follow-up care from another health professional.

We use and disclose your health information for the purpose of receiving payment for our services which includes: (1) submission to a billing agent or vendor, (2) to third-party payers or insurers for claims review, determination of benefits and payment (3) to auditors hired by third-party payers and insurers and (4) other aspects of payment described in the Notice of Privacy Practices.

When you sign this document, you agree that we may use and disclose your health information for the purpose of treatment, payment and to perform the necessary administrative functions in our office.

You have the right to restrict the use and disclosure of your health information for the purpose of treatment, payment and administrative duties, however as described in our **Notice of Privacy Practices,** we are not obligated to the restrictions. If we do agree to the restriction is binding on us.

I have read this document and understand it. I consent *to* the use and disclosure of my health information for the purpose of treatment, payment and administrative functions. I acknowledge that I have received the Notice of Privacy Practices from Frank W. Shagets M.D.

Patient Signature: _____ Date: _____

Parent(s) Signature (if minor) _____ Date: _____

I give permission for test results/messages to be released to:	Name	Relationship
	_____	_____
	_____	_____

May we leave messages on home answering machine?	Yes	No
May we leave messages on cell answering machine?	Yes	No