PANORAMA
Orthopedics & Spine Center

# Patient Policy Acknowledgement

Patient Name_____ Date of Birth_____

**Panorama Orthopedics Patient Communication Policy**:

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*Initials*

Under HIPAA, we may discuss your protected health information, including **care or financial information** with individuals involved in your care if you are not present or do not have the capacity to agree or object, if in the professional judgment of POSC physician or other caregiver, we conclude that the disclosure is in your best interest. The disclosure is limited, in this circumstance, to protected health information that is directly relevant to that individual's involvement in your care. If you would like to identify specific individuals to whom we may make the foregoing disclosures, such as in the event POSC is unable to reach you or in response to an inquiry, please list them here: _____.

Communications: Please specify certain ways we may or may not communicate with you. This is to include appointment reminders, test results, prescription refills and financial communications.

[ ] YES [ ] NO Leave Messages on my answering machine/voice mail
[ ] YES [ ] NO Leave Messages with any other person answering the phone
[ ] YES [ ] NO Utilize text messaging for appointment reminders **Cell**:_____
[ ] YES [ ] NO Attempt to contact me via the provided email address

_____
*Initials*

I understand the contact information on the **Registration Form** will be relied upon to communicate with me regarding my medical and financial information until such time as I notify POSC in writing of a change, at the address listed below.

_____
*Initials*

**HIPAA Acknowledgement:** I acknowledge I have been provided with POSC's Notice of Privacy Practices or with an opportunity to obtain a copy and I have declined. PLEASE SEE THE POSC NOTICE OF PRIVACY PRACTICES FOR A COMPLETE STATEMENT OF OUR USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION AND YOUR ASSOCIATED RIGHTS. OUR NOTICE OF PRIVACY PRACTICES IS AVAILABLE ON OUR WEBSITE, WWW.PANORAMAORTHO.COM OR AT ANY OF OUR OFFICES.

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*Initials*

**Electronic Medical Records and Prescription Access:** I acknowledge that the office uses electronic medical records and may use such system to look at and prescribe medications.

_____ _____
Printed Name Date Signature of Patient/Guardian

_____
Reason Patient Unable to Sign/Guardian Relationship

For further questions, or to change/revoke your information, please contact our Privacy Officer at:
Telephone: 303-233-1223
Address: Panorama Orthopedics and Spine Center
660 Golden Ridge Road, Suite 250
Golden, CO 80401
Website: www.panoramaortho.com

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