

Clinic location:
 1001 S 70th St,
 Suite 100
 Lincoln, NE 68510

Sylvia Trotter, DPM
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Mailing address:
 PO Box 67035
 Lincoln, NE 68506
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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Printed patient name: _____ **Birth Date:** _____

I understand that Complete Family Foot Care may need to use and disclose information about my health or medical problems for the purpose of arranging, conducting, or referring for my treatments, for obtaining payment for the services rendered to me and for the operations of the practice. I consent to the use of my information for the purposes of treatment, payment and healthcare operations.

I understand that my consent is not needed if the law requires Complete Family Foot Care to report some aspect of my protected health information to a government agency. Examples would include suspected abuse, communicable disease and potential for serious bodily harm to myself or others.

I acknowledge that I was provided a copy of Complete Family Foot Care’s full-length Notice of Privacy Practices to read and that I was provided a printed copy if desired.

Authorized Signature: _____ Date: _____

Relationship to patient: Self Parent POA

OPTIONAL

Sometimes friends or family members need to be involved in decision making. By completing this section, I give my consent for Complete Family Foot Care to give the checked information to the persons I have listed below:

Person’s Name	Phone Number	What I want them to have access to if needed:		
		Health Information	Billing Information	Appointment Schedule
_____	_____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
_____	_____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
_____	_____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
_____	_____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Signature: _____ Date: _____

****Only needed if optoinal section is filled out****