DRS. GAULT, FISHBEIN, & ASSOCIATES

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights of privacy regarding my protected health information. I understand that, when applicable, this information can and will be used to:

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

I understand that it is my responsibility for all payments to my provider at the offices of Drs. Gault, Fishbein, and Associates. I hereby consent to the release of any medical information necessary to process my insurance claims to my treating psychologist/psychiatrist at Drs. Gault, Fishbein, and Associates.

Signature of Patient _____ **DATE**_____
(If over 12 years old)

Signature of Parent/Guardian_____ **DATE** _____

If we need to contact you, please list the numbers we may use to contact you:

Patient's Home# (_____)_____ Cell# (_____)_____
Work# (_____)_____ May we leave a message ? Y/N _____
Email address: _____

Children Under Age 18

Mother's Home# (_____)_____ Cell# (_____)_____
Work# (_____)_____ May we leave a message ? Y/N _____
Email address: _____

Father's Home# (_____)_____ Cell# (_____)_____
Work# (_____)_____ May we leave a message ? Y/N _____
Email address: _____

I have read and understand this document, as well as understand the Financial Agreement and Office Policy, and agree to these provisions.

Signature of Patient _____ **DATE**_____
(If over 12 years old)

Signature of Parent/Guardian_____ **DATE** _____