



COMMUNICATION & HIPAA PRIVACY POLICY

Excellent communication is a very important part of providing quality healthcare. In an effort to provide you with the timeliest information regarding your healthcare, we are asking you to complete this waiver.

- We normally contact our patients between 9:00 AM to 4:30 PM. During this time what is the phone number we should use to contact you?

(_____) _____ Home ____ Cell ____ Work ____

- If you are unavailable at the time we try to contact you, may we leave medical information on voicemail or an answering machine?

Yes ____ No ____

- If you are unavailable at the time we try to contact you, may we leave appointment reminders via voicemail?

Yes ____ No ____

- If you are unavailable at the time we contact you, may we leave medical information with another person?

Yes ____ No ____

If yes, with whom? _____ (name & relationship)

- The most efficient way to contact a provider or staff member at our practice is by sending a message through the patient portal. We are trying to reduce the number of calls coming into the practice, which will allow the practice to contact you in a timely manner and eliminate "phone tag." Please initial below to indicate that you acknowledge that the portal is the best way to communicate with us.

Patient Initials: _____

- I authorize HealingSpace to obtain/have access to my medication history via SureScripts.

Yes ____ No ____



HIPAA PRIVACY POLICY

Your privacy is important to HealingSpace Medical Center. In order to ensure that we provide the highest level of service for your medical needs, our office collects both personal and medical information from you. Your information may be released to your insurance company to receive reimbursement for services rendered. HealingSpace will take reasonable technical and organizational precautions to prevent the loss, misuse, or alteration of your personal information. HealingSpace stores all personal information you provide on our secure server.

A copy of HealingSpace HIPAA Privacy Policies are available for your review at your request.

I hereby acknowledge receipt of HealingSpace Communication/HIPAA Privacy Policy

Patient Name: _____ Date: _____

Signature: _____