Abdallah Karam, MD, SC
HIPAA – Patient Acknowledgement Form

I, _____, hereby acknowledge receipt of the Dr. Karam's Notice of
(Patient's Name)

Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available by mail or from the office website at www.yourdockares.com.

I authorize release of any medical information necessary to process insurance claims and payment of medical benefits directly to Dr. Karam.

I understand that my insurance company may not cover services due to reasons such as: lack of coverage, non-covered services, services not meeting "Medical Necessity, or too many services within your insurance carrier's definition of "Time Period." If my insurance company denies payment, I agree to be personally and fully responsible for payment of all charges.

I_____DO or _____DO NOT consent to my medical records to be provided through data exchange with my other medical providers.

I _____ DO or _____ DO NOT request a chaperone in the exam room during the physical portion of my exam with Dr. Karam.

I authorize Dr. Karam and/or his staff to discuss my medical treatment with:
Only Myself:_____

Doctor:_____Phone:_____ Doctor:_____Phone:_____

Name: _____ Relationship:_____ Phone:_____

Name:_____Relationship:_____Phone:_____

I prefer to be contacted by a phone call to: Home:_____ Cell:_____ Work:_____

Messages may be left on my answering machine or voicemail: YES:_____ NO:_____

Messages may be left with one of the people listed above: YES:_____ NO:_____

EMERGENCY CONTACT NAME_____ PHONE:_____
Relationship to you?_____

Email. YES:____ NO:____ Please provide email address:_____

All mail will be sent to your home address and no information will be faxed to you without your permission.

Signed: _____ Date: _____
If you are not the patient, please specify your relationship to the patient _____. REV. 1.18.2018