YOUR *next* STEP
The Foot and Ankle Care Center

Eric Ricefield, DPM
Mark Yagodich, DPM
Aliza Eisen, DPM

39 RITTENHOUSE PLACE
ARDMORE, PA 19003
(610) 642-8837

1410 RUSSELL ROAD, SUITE 201
PAOLI, PA 19301
(610) 644-6501

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE AND CONSENT TO USE HEALTH INFORMATION

Read before signing the Acknowledgment and Consent

This acknowledgment of notice and consent authorizes Your Next Step, PC to use your health information about you for treatment, payment, and health care operations purposes.

Notice of Privacy Practices Your Next Step, PC has a Notice of Privacy Practices, which describes how we may use your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgment and consent.

If you would like to receive a copy of the Privacy Notice, please request one at the time of your appointment.

Amendments We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

How to contact our Privacy Officer:

Mail: Your Next Step, PC
Attention: Alan Spiegel, Privacy Officer
39 Rittenhouse Place
Ardmore, PA 19003

Acknowledgment and Consent

I have received the Notice of Privacy Practices for Your Next Step, PC. Your Next Step, PC is authorized to use health information about (please print patient's name) _____ for treatment, payment, and healthcare operations purposes consistent with its Notice of Privacy Practices.

_____

Signature of Patient Date MRN

Personal representative information (if applicable):

_____ _____

Name of Personal Representative Relationship to Patient

Please provide us with your contact information and the name or other specific identification of the person(s) or class of persons to whom the covered entity may disclose the covered information:

____ I prefer to be contacted by my physician/physician's office at the following phone #(s) *(Please circle the best day time phone #)*
Home: _____ Cell: _____ Other: _____
Do we have permission to leave a message? ❑ Yes ❑ No

_____ You have permission to speak with the designated/authorized person(s) named:
_____

_____ You have permission to contact me via email at the following email address:

_____