# *Georgia Plastic Surgery, P.C.*
# *HIPAA Acknowledgment*

**Please sign statement (a) or statement (b):**

(a) I have received a copy of Georgia Plastic Surgery, P.C.'s Notice of Privacy Practices for Protected Healthcare Information

______________________________ ______________________________
Patient or Representative Signature Date

(b) I have declined a copy of Georgia Plastic Surgery, P.C.'s Notice of Privacy Practices for Protected Healthcare Information

______________________________ ______________________________
Patient or Representative Signature Date

**Please answer the following questions**:

Which of the following methods of communication may we use to contact you to ask questions, give information, and confirm appointments?

| | | | |
|---|---|---|---|
| Home | ☐ Yes | ☐ No | Home Number ______________________ |
| Work | ☐ Yes | ☐ No | Work Number ______________________ |
| Cell | ☐ Yes | ☐ No | Cell Number ______________________ |
| Email | ☐ Yes | ☐ No | Email address______________________ |
| Other | ☐ Yes | ☐ No | Other ______________________ |

May Georgia Plastic Surgery, P.C. send you newsletters and notices of special offers via email?
☐ Yes ☐ No Email address ______________________________

May Georgia Plastic Surgery, P.C. contact you regarding treatment options or alternatives and health-related benefits or services that we believe may be of interest to you?
☐ Yes ☐ No

**Please note, your information will not be shared with any third-party organization unless they work directly with Georgia Plastic Surgery, P.C. to facilitate treatment, payment, or health care operations for our practice.**

Comments:____________________________________________________________

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