PRACTICE'S REQUIREMENTS

The Practice is required by federal law to maintain the privacy of your Patient Health Information (PHI) and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practice with respect to your PHI.

Under the Privacy Rule, the Practice may be required by state law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law.

The Practice is required to abide by the terms of this Privacy Notice.

The Practice reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.

The Practice will distribute any revised Privacy Notice to you prior to implementation.

The Practice will not retaliate against you for filing a complaint.

EFFECTIVE DATE

THIS NOTICE IS EFFECTIVE AS OF MAY, 2016

To obtain more information about your privacy rights or if you have questions you want answered about your privacy rights (as provided for by Privacy Rule, Section 164.520(b)(vii), you may contact the Practice's HIPPA Compliance Officer as follows:

MAIL: Dr. Jerald Kriger
8605 Sudley Road
Manassas, VA 20110

EMAIL: manassasfootdoc@aol.com

PHONE: 703-330-4450

Amendments to this Privacy Policy: We reserve the right to revise or amend this Privacy Policy at any time. These revisions or amendments may be made effective for all protected health information we maintain even if created or received prior to the effective date of the revision or amendment. We will provide you with notice of any revisions or amendments to this Privacy Policy, or changes in the law affecting this Privacy Notice, within sixty (60) days of the effective date of such revision, or change.

Revised May 01, 2016

NOTICE OF PRIVACY PRACTICES (HIPPA REGULATIONS)

You were provided with a document entitled "Practice's Requirements". It is required by governmental regulations that all medical facilities provide you with this notice. Please sign below to acknowledge that you have read (or had the opportunity to read) and understand the notice. This is a copy of the notice that is yours to keep. If you do not want the copy, simply return it to the front office with your other materials.

CONSENT:

I certify that the information above is true and correct to the best of my knowledge. I give permission to the doctor to administer and perform such procedures, including therapeutic and diagnostic injections,m as may be deemed necessary in the diagnosis and/or treatment of my feet.

Signature:________________________________ **Date:**_____/_____/______