ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICE
Fondren Orthopedic Group LLP

I, (name of patient) _____ , acknowledge and agree that I have reviewed a copy of Fondren Orthopedic Group's Notice of Privacy Practices and have completed the form below to the best of my knowledge.

Signature of Patient or Guardian	Relationship to Patient	Date

Clinic Use Only

Fondren Orthopedic Group, L.L.P. made the following good faith efforts to obtain the above-referenced individual's written acknowledgment of the Notice of Privacy Practices:

Signature of Employee	Date

FAMILY AND FRIENDS

Persons who are involved in your care (family "spouses", friends, other doctors "PCP" etc.) may inquire about your treatment, lab results, prescriptions, etc. IF THEY ARE NOT ON THIS LIST, WE CANNOT SPEAK WITH THEM REGARDING YOU. Please let us know what person(s) we may share information with and list them below.

_____ _____

_____ _____

_____ _____

_____ _____

What other ways may we contact you? From time to time we will need to leave a message for you (as stated in our Notice of Privacy Practices) on answering machine, voice mail, or another individual in your absence. Is it OK to leave a message that includes details (such as diagnosis and medication information) at the numbers you have provided below:

Home Number: _____ YES or NO

Work Number: _____ YES or NO

Cell Number: _____ YES or NO

Other Number: _____ YES or NO