Patient Information

Last: _____ First: _____ O Female O Male Date of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____
2 Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____
Email: _____ Referred By: _____

Emergency Contact

Name: _____ Relation: _____ Phone: _____

Insurance Information

Name of Insured: _____ Relationship to Patient: _____
Insured's Date of Birth: _____ Insured's SS# _____ Patient of Office? O Yes O No
Employer: _____ Employer Address: _____ Employer Phone: _____

Patient Consent Form

I understand that, under the Health Insurance Portability and Accountability Act of 1966 (HIPAA) I have certain rights to privacy regarding my protected health information, I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physicians certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and discourses of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time and that I may contact this organization at the address above to obtain a current copy of *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do not agree, then you are bound to abide by such restrictions.

I understanf that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

_____

Print Name Date

_____

Signature Relationship to Patient