PRIVIA MEDICAL GROUP NORTH TEXAS

PHYSICIAN: ______________________ BEING SEEN TODAY

LOCATION: ______________ DATE: ______________

PATIENT REGISTRATION INFORMATION

If Patient cannot be billed for these services (for example, minor children), please complete RESPONSIBLE PARTY SECTION below as well as this patient registration information section.

Social Security #: ______________ Driver's License # ______________ State: ______

Name: ______________ LAST ______________ FIRST ___ MI ___ SEX MM ___/ DD ___/ YY ___ DATE OF BIRTH ___ AGE S M D W O MARITAL STATUS

Address: ______________ MAILING ADDRESS ______ APARTMENT ______ CITY ___ ST ______ ZIP (____) ______ HOME PHONE

Alt/Cell Phone: (____)______________ Day Phone: (____)______________ Email: ______________

Race______________ Language______________ Ethnicity ☐ Hispanic/Latin ☐ Non Hispanic/Latin

Full-Time Part-Time Retired Unemployed Student
EMPLOYMENT STATUS (PLEASE CIRCLE ONE)

Employer's Name: or School ______________

Employer's Address: ______________ MAILING ADDRESS ______ CITY ___ ST ______ ZIP

Occupation: ______________

Emergency Contact: *(Please indicate a friend or relative not living at the same address.)*

______________ NAME ______________ RELATIONSHIP (____) ______________ EMERGENCY CONTACT #

RESPONSIBLE PARTY AND BILLING INFORMATION

Patient is responsible unless a minor child or guardian. RESPONSIBLE PARTY SECTION must be completed.

Patient Relationship to Responsible Party: Child ____ Other ______________ SPECIFY Resp. Party SS #: ______________

Name: ______________ LAST ______________ FIRST ___ MI ___ SEX MM ___/ DD ___/ YY ___ DATE OF BIRTH ___ AGE S M D W O MARITAL STATUS

Address: ______________ MAILING ADDRESS ______ APARTMENT ______ CITY ___ ST ______ ZIP (____) ______ HOME PHONE

Full-Time Part-Time Retired Unemployed Student
EMPLOYMENT STATUS (PLEASE CIRCLE ONE)

Employer's Name: or School ______________

Employer's Address: ______________ MAILING ADDRESS ______ CITY ___ ST ______ ZIP

Occupation: ______________ (____) ______________ WORK PHONE (____) EXT

OTHER PATIENT INFORMATION

Spouse's Name: ______________ Employer: ______________

___/___/___ DATE OF BIRTH Spouse's Work Phone: (____) ______________ (______) EXT Occupation: ______________

PRIMARY INSURANCE

Please complete the information below and provide a copy of the insurance card.

Insurance Company: ______________ Address: ______________ STREET or P.O. BOX (____) ______ PHONE

Co-Pay Amount: (if applicable) ______________ ______________ CITY ___ ST ______ ZIP

Primary Care Physician: ______________

Policy Holder: ______________ LAST ______________ FIRST ___ MI ___ SEX ____/____/____ DATE OF BIRTH ______ SS #

Patient Relationship to Insured Party: Self___ Spouse___ Child___ Other______________ (SPECIFY)

Employer's Name: ______________ ______________ INSUREDS ID ______________ GROUP NAME AND/OR NUMBER

Address: ______________ STREET ______________ CITY ___ ST ______ ZIP

THC99P02

SECONDARY INSURANCE

Please complete the information below and provide a copy of the insurance card.

Insurance Company: ______________________ Address: ______________________ (____) __________
STREET or P.O. BOX PHONE

Co-Pay Amount: (if applicable) ______________________ ______________ ______ ________
CITY ST ZIP

Primary Care Physician: ______________________

Policy Holder: ______________________ ____ ____ ____/____/____ ________
LAST FIRST MI SEX DATE OF BIRTH SS #

Patient Relationship to Insured Party: Self___ Spouse___ Child___ Other ______________________
(SPECIFY)

Employer's Name: ______________________ ______________ ______________
INSUREDS ID GROUP NAME AND/OR NUMBER

Employer's Address: ______________________ ______________ ______ ________
STREET CITY ST ZIP

WORKER'S COMPENSATION

Worker's Compensation Insurance Name: ______________________ Adj. __________

Address: ______________ City: __________ State __________ Zip __________ Phone __________

Claim #: ______________________ DOI ______________________

What Employer: ______________________

ACCIDENT INFORMATION

Was this the result of an accident? ___Yes ___No Where did it occur? ___At Work ___Auto Accident ___Other

Date of Accident__________Have you reported this injury to your employer? ___Yes ___No When __________

Describe accident briefly: ______________________

Do you have an attorney representing you? ___Yes ___No Who is the attorney? ______________________

REFERRAL INFORMATION

Who referred you? ______________ Address: ______________ Phone: __________

Family Physician ______________ Address: ______________ Phone: __________

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION/NOTICE OF PRIVACY PRACTICES/APPOINTMENT OF AUTHORIZED REPRESENTATIVE

PLEASE READ

Privia Medical Group North Texas (PMG), and its physicians are committed to securing the privacy of your health information. Accord-ingly, we have posted our "Notice of Privacy Practices" in the reception area. You are not required to read this notice. However, we would like your acknowledgement that you have been advised that PMG has such a Notice of Privacy Practices.

I hereby assign, transfer and set over to PMG, all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits, including medical, surgical, psychiatric and/or substance abuse (drug or alcohol) information. This authorization shall remain valid until written notice is given by me revoking said authorization.

I understand that this order does not relieve me of my obligation to pay such bills if not paid/covered/found medically necessary by my commercial/third party/government plan or insurance company. I am also financially responsible for any balances due after payments by my insurance company.

I appoint PMG to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment.

All charges are due at the time of service. If surgery is indicated, I am responsible for furnishing insurance claim forms to the office prior to surgery.

______________________ __________ ______________________ __________
PATIENT SIGNATURE DATE WITNESS SIGNATURE DATE

John L. Fewins, MD, FACS

PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **Please fill out every item.** It is important for your doctor to know that you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcome to a copy of the report if you wish.

Full Name ______________________________ **Appointment Date** ____________________

Male ☐ **Female** ☐ **Date of Birth** ________________ **HT:**______**WT:**_______

Pharmacy Preference **(include location)**____

Name of Primary Care Physician ______________________ **Name of Referring Physician**_________________________

Are you taking ANY kind of medication now? (This includes prescription, over-the-counter or herbal medications)
☐ **No** ☐ **Yes If yes, please list below *include dosages*.**

Medication Name	Dosage	How often taken

ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐ **No** ☐ **Yes If yes, please list below.**

Name of Medication	Type of Reaction

SURGERIES AND HOSPITALIZATIONS

Have had problems with anesthesia (being numbed or put to sleep)? ☐ **No** ☐ **Yes**

Have had any ear nose or throat surgery? ☐ **No** ☐ **Yes (type and date)**__________________________

____

____

Have had any other surgeries? ☐ **No** ☐ **Yes**
(type and date)____

____

Have you ever been hospitalized for non-surgical reasons? ☐ **No** ☐ **Yes** If so please explain

____

Patient Health History

Name:________________________________ **Email:**______________________________________

Are you allergic to any of the following? (please circle if yes)

Adhesive Tape   Metal   Iodine   Seafood   Latex   Contrast Dye

Please circle if YOU have been diagnosed with any of the following:

Cancer: Breast Lung Skin Throat Prostate Other? Please list type______________________________

Nasal allergies Sleep Apnea Blood Clots High Cholesterol Heart Attack High Blood Pressure

Asthma Emphysema Reflux Hepatitis Anxiety Depression

Diabetes Thyroid Dysfunction HIV Tuberculosis Anemia

Please mark family members who have been diagnosed with any of the following:

	Mother	Father	Brother	Sister	
Thyroid cancer	____	____	____	____	
Lung cancer	____	____	____	____	
Other cancer	____	____	____	____	type_________________________
Hearing Loss	____	____	____	____	
Heart Disease	____	____	____	____	
Asthma	____	____	____	____	
Stroke	____	____	____	____	
Diabetes	____	____	____	____	

Do you use tobacco? Yes__ no___Former___ How much___________Age started____ Age stopped______

How often do you drink alcoholic beverages: Never___ Daily:___ Weekly:___ Occasionally___
Recreational drug use? Yes____ no____

Daily Caffeine intake: (please circle type) Coffee Tea Soda Chocolate Other caffeinated drinks

none:_______ 1 per day_____ 2-3 per day_____ 4 or more per day______

Do you have now, or have you recently had any of the following? (please circle):

Fever	Sleeping Issues	Weight Loss	Weight Gain	Appetite Increase	Blurred vision	Itchy eyes	Vision loss
Eye pain	Hives	Sneezing	Severe face pain	Dizziness	Ear Drainage	Hearing loss	Ear pain
Ringing in ear	Headache	Seizures	Tremor	Nasal Congestion	Past nasal drip	Nosebleeds	Change in Smell
Change in Taste	Belching/Sour	Chest pain	Heart murmur	Irreg. Heart rate	Leg cramps	Swelling of ankle	Snoring
Wheezing	Abdominal pain	Diarrhea	Nausea	Vomiting	Fatigue	Cold feeling	Bruise easily
Hoarseness	Other voice change	Mouth Ulcers	Partials	Dentures	Blacking out Fainting	Frequent NON productive cough	Frequent Productive cough
Shortness of Breath	Painful joints	Stiffness in joints	Swelling of joints	Bruise excessively	Masses(lumps) in armpits	Masses(lumps) in Neck	Masses (lumps) in Groin

Patient Name: _______________________ **Date of Birth:** __________________

BMI Screening: When your Height and Weight are entered into our Electronic Health Record, your Body Mass Index (BMI) is calculated automatically. If your BMI is considered above or below normal, we are required to give you information pertaining to a healthy lifestyle of diet and/or exercise. We recommend you visit the Center for Disease Control's website for more information. http://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/index.html

Pneumonia Vaccination Status: If you are 65 years of age or older, it is recommended that you get a Pneumococcal vaccination.

Have you had a Pneumonia Vaccination? Yes No N/A Approximate date of your last vaccination? _____________

If no, please talk with your Primary Care Physician about getting one. For more information on the Pneumococcal vaccine please visit the Center for Disease Control's website at http://www.cdc.gov/VACCINes/vpd-vac/pneumo/default.htm

Breast Cancer Screening: If you are a female 40-69 years of age, it is recommended that you get regular screenings for breast cancer. Although it is not necessarily related to your visit at our office, we are being required to ask if you have had your screening tests.

Have you had a mammogram? Yes No N/A Approximate date of your last mammogram? __________________

If no, please talk to your Primary Care Physician or Gynecologist about ordering a mammogram. For more information on mammograms please visit the American Cancer Society's website at www.cancer.org

Colorectal Cancer Screening: If you are 50-75 years of age, it is recommended that you get regular screenings for colorectal cancer. Although it is not necessarily related to your visit at our office, we are being required to ask if you have had your screening test(s).

Have you had a colonoscopy? Yes No N/A Approximate date of your last colonoscopy? ____________________

If no, please talk to your Primary Care Physician about ordering a colonoscopy. For more information on colonoscopies please visit the American Cancer Society's website at www.cancer.org

Tobacco Use: If you are 18 years old or older: Have you *EVER* used any type of tobacco product (including smokeless products)?

Please circle: **Never** **Current** **Former**

If **NEVER**, you are finished.

If **CURRENT** or **FORMER**, please answer the following questions to the best of your abilities:

1. Type of tobacco used: ____
2. How much per day:____
3. Approximate age started:____
4. Have you ever tried to stop? _____ If yes, approximate age:_______________________
5. What method did you use to try to stop (if applicable):__________________________
6. Approximate age stopped successfully (if applicable): _____________________________

Please visit the Center for Disease Control's website for additional information on Tobacco cessation. http://www.cdc.gov/tobacco

PRIVIA MEDICAL GROUP NORTH TEXAS

CONSENT FOR TREATMENT

By signing this consent, I am authorizing my physician(s) and /or another person to perform all exams, tests, procedures, injections, phlebotomy, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. Examples of these tests include nasal endoscopy, laryngoscopy, audiogram and tympanogram.

This consent is valid for each visit I make to **Dr. John L. Fewins**, with Privia Medical Group North Texas unless revoked by me in writing.

Please ask Dr. Fewins if you have any questions about the nature of any diagnostic test. Please contact your insurance provider should you have questions regarding the way the charges will be processed.

______________________________ ____________________
Patient Name Date of Birth

______________________________ ____________________
Patient or Guardian Signature Date

Privia Medical Group North Texas

HIPAA Authorization for Release of Patient Health Information

In general, HIPAA (Health Insurance Portability & Accountability Act) gives patients the right to request the uses and disclosures of their protected health information (PHI). The patient is also provided the right to request confidential communications, or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of home. This information will remain in effect until revoked in writing, except to the extent that action has already been taken.

I wish to be contacted in the following manner (check all that apply):

- ☐ Home or Cell Phone: ____________________
  - ❍ OK to leave a message with detailed information
  - ❍ Leave name and doctor with call back number only
- ☐ Work Telephone: ____________________
  - ❍ OK to leave message with detailed information
  - ❍ Leave name & doctor with call back number only
- ☐ When unable to contact me by phone, a written communication may be sent to my home address.
- ☐ Other: ____________________

I consent and authorize the release of **NORMAL** test results to the following:

- ☐ Only Myself
- ☐ Telephone Answering Machine/Voice Mail
- ☐ My spouse: ____________________
- ☐ My children: ____________________
- ☐ My parents: ____________________
- ☐ Other: ____________________

I consent and authorize the release of **ABNORMAL** test results to the following:

- ☐ Only myself
- ☐ Telephone Answering Machine/Voice Mail
- ☐ My spouse: ____________________
- ☐ My children: ____________________
- ☐ My parents: ____________________
- ☐ Other: ____________________

I consent and authorize your office or a facility on my behalf, to conduct benefit verification services.

- ☐ Yes
- ☐ No

I hereby give my physician permission to discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medications prescribed by my other physician(s).

- ☐ Yes
- ☐ No

ADVANCED DIRECTIVE

Do you have an advanced directive (Living Will)?

- ☐ Yes
- ☐ No

____

Patient Signature (Must be an adult 18 yrs or older) Date

____

Print Name Birthdate

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This practice uses and discloses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive.

This notice describes our privacy practices. You can request a copy of this notice at any time. For more information about this notice or our privacy practices and policies, please contact the practice team liaison in this office.

Treatment, Payment, Health Care Operations

We are permitted to use and disclose your medical information to those involved in your treatment. Texas Health Care, PLLC is a multi-specialty practice and when we provide treatment, we may request that all of your physicians share your medical information with us. For example, your care may require both primary care physicians and specialty care physicians. When we provide treatment, we may request information from all of your physicians so that we can appropriately treat you for all other medical conditions, if any.

- If your physician is a primary care physician, your care may require the involvement of a specialist. When we refer you to a specialist, we will share some or all of your medical information with that physician to facilitate the delivery of care.
- If your physician is a specialist, when we provide treatment, we may request that your primary care physician share your medical information with us. Also, we may provide your primary care physician information about your particular condition so that he or she can appropriately treat you for other medical conditions, if any.
- If your treatment has been ordered by your physician, but is being provided by an ancillary department, such as any therapies, we are permitted to use and disclose your medical information to those involved in your treatment. When we provide treatment, we may request that your physician share your medical information with us. Also, we may provide your physician information about your particular condition so that he or she can appropriately treat you for other medical conditions, if any.

Payment

We are permitted to use and disclose your medical information to bill and collect payment for the services provided to you. For example, we may complete a claim form to obtain payment from your insurer or HMO. The form will contain medical information, such as a description of the medical service provided to you, that your insurer or HMO needs to approve payment to us.

Health Care Operations

We are permitted to use or disclose your medical information for the purposes of health care operations, which are activities that support this practice and ensure that quality care is delivered

For example, we may ask another physician to review this practice's charts and medical records to evaluate our performance so that we may ensure that only the best health care is provided by this practice.

Disclosures That Can Be Made Without Your Authorization

There are situations in which we are permitted by law to disclose or use your medical information without your written authorization or an opportunity to object. In other situations we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or taken in reliance on that authorization.

Public Health, Abuse or Neglect, and Health Oversight

We may disclose your medical information for public health activities. Public health activities are mandated by federal, state, or local government for the collection of information about disease, vital statistics (like births and death), or injury by a public health authority. We may disclose medical information, if authorized by law, to a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. We may disclose your medical information to report reactions to medications, problems with products, or to notify people of recalls of products they may be using.

We may also disclose medical information to a public agency authorized to receive reports of child abuse or neglect. Texas law requires physicians to report child abuse or neglect. Regulations also permit the

disclosure of information to report abuse or neglect of elders or the disabled.

We may disclose your medical information to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure applications and inspections which are all government activities undertaken to monitor the health care delivery system and compliance with other laws, such as civil rights laws.

Legal Proceedings and Law Enforcement

We may disclose your medical information in the course of judicial or administrative proceedings in response to an order of the court (or the administrative decision-maker) or other appropriate legal process. Certain requirements must be met before the information is disclosed.

If asked by a law enforcement official, we may disclose your medical information under limited circumstances provided that the information:

- Is released pursuant to legal process, such as a warrant or subpoena;
- Pertains to a victim of crime and your are incapacitated;
- Pertains to a person who has died under circumstances that may be related to criminal conduct;
- Is about a victim of crime and we are unable to obtain the person's agreement;
- Is released because of a crime that has occurred on these premises; or
- Is released to locate a fugitive, missing person, or suspect.

We may also release information if we believe the disclosure is necessary to prevent or lessen an imminent threat to the health or safety of a person.

Workers' Compensation

We may disclose your medical information as required by the Texas workers' compensation law.

Inmates

If you are an inmate or under the custody of law enforcement, we may release your medical information to the correctional institution or law enforcement official. This release is permitted to allow the institution to provide you with medical care, to protect your health or the health and safety of others, or for the safety and security of the institution.

Military, National Security and Intelligence Activities, Protection of the President

We may disclose your medical information for specialized governmental functions such as separation or discharge from military service, requests as necessary by appropriate military command officers (if you are in the military), authorized national security and intelligence activities, as well as authorized activities for the provision of protective services for the President of the United States, other authorized government officials, or foreign heads of state.

Research, Organ Donation, Coroners, Medical Examiners, and Funeral Directors

When a research project and its privacy protections have been approved by an Institutional Review Board or privacy board, we may release medical information to researchers for research purposes. We may release medical information to organ procurement organizations for the purpose of facilitating organ, eye, or tissue donation if you are a donor. Also, we may release your medical information to a coroner or medical examiner to identify a deceased or a cause of death. Further, we may release your medical information to a funeral director where such a disclosure is necessary for the director to carry out his duties.

Required by Law

We may release your medical information where the disclosure is required by law.

Other uses and Disclosures

We will not use or sell your protected health information for marketing or any other purposes without your expressed permission.

Your Rights Under Federal Privacy Regulations

The United States Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPAA). Those regulations create several privileges that patients may exercise. We will not retaliate against a patient that exercises their HIPAA rights.

Requested Restrictions

You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or healthcare operations.

- If you have health insurance coverage and personally pay, out-of-pocket, in full for medical services provided, you may request that we not submit any information regarding these services to your insurance carrier.
- To request this restriction, notify the front desk of the physician's office. You will be provided with a separate form documenting this request. Please give or send the request to the Practice Team Liaison in this office.

You may also request that we limit disclosure to family members, other relatives, or close personal friends that may or may not be involved in your care.

Receiving Confidential Communications by Alternative Means

You may request that we send communications of protected health information by alternative means or to an alternative location. This request must be made in writing to the person listed below. We are required to accommodate only *reasonable* requests. Please specify in your correspondence exactly how you want us to communicate with you and, if you are directing us to send it to a particular place, the contact/address information.

Inspection and Copies of Protected Health Information

You may inspect and/or copy health information that is within the designated record set, which is information that is used to make decisions about your care. Texas law requires that requests for copies be made in writing and we ask that requests for inspection of your health information also be made in writing. Please send your request to the person listed below.

We can refuse to provide some of the information you ask to inspect or ask to be copied if the information:

- Includes psychotherapy notes.
- Includes the identity of a person who provided information if it was obtained under a promise of confidentiality.
- Is subject to the Clinical Laboratory Improvements Amendments of 1988.
- Has been compiled in anticipation of litigation.

We can refuse to provide access to or copies of some information for other reasons, provided that we provide a review of our decision on your request. Another licensed health care provider who was not involved in the prior decision to deny access will make any such review.

Texas law requires that we are ready to provide copies or a narrative within 15 days of your request. We will inform you of when the records are ready or if we believe access should be limited. If we deny access, we will inform you in writing.

HIPAA permits us to charge a reasonable cost based fee. The Texas State Board of Medical Examiners (TSBME) has set limits on fees for copies of medical records that under some circumstances may be lower than the charges permitted by HIPAA. In any event, the *lower* of the fee permitted by HIPAA or the fee permitted by the TSBME will be charged.

Amendment of Medical Information

You may request an amendment of your medical information in the designated record set. Any such request must be made in writing to the person listed below. We will respond within 60 days of your request. We may refuse to allow an amendment if the information:

- Wasn't created by this practice or the physicians here in this practice.
- Is not part of the Designated Record Set?
- Is not available for inspection because of an appropriate denial.
- If the information is accurate and complete.

Even if we refuse to allow an amendment you are permitted to include a patient statement about the information at issue in your medical record. If we refuse to allow an amendment we will inform you in writing. If we approve the amendment, we will inform you in writing, allow the amendment to be made and tell others that we know have the incorrect information.

Accounting of Certain Disclosures

The HIPAA privacy regulations permit you to request, and us to provide, an accounting of disclosures that are other than for treatment, payment, health care operations, or made via an authorization signed by you or your representative. Please submit any request for an accounting to the person listed below. Your first accounting of disclosures (within a 12 month period) will be free. For additional requests within that period we are permitted to charge for the cost of providing the list. If there is a charge we will notify you and you may choose to withdraw or modify your request *before* any costs are incurred.

Appointment Reminders, Treatment Alternatives, and Other Health-related Benefits

We may contact you by telephone, mail, or both to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

Complaints

If you are concerned that your privacy rights have been violated, you may contact our Privacy Officer. You may also send a written complaint to the United States Department of Health and Human Services. We will not retaliate against you for filing a complaint with the government or us. The contact information for the United States Department of Health and Human Services is:

U.S. Department of Health and Human Services
HIPAA Complaint
7500 Security Blvd., C5-24-04
Baltimore, MD 21244

Our Promise to You

We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of our privacy practices with respect to protected health information, and to abide by the terms of the notice of privacy practices in effect.

Questions and Contact Person for Requests

If you have any questions or want to make a request pursuant to the rights described above, please contact:

Jason Copling, Privacy Officer
Texas Health Care
2821 Lackland Road, Suite 300
Fort Worth, TX 76116
(817) 740-8400
jcopling@txhealthcare.com

This notice is effective on the following date: March 1, 2013.

We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen.

Acknowledgement of Review of
Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

____
Signature of Patient or Personal Representative

____
Date

____
Name of Patient or Personal Representative

____
Description of Personal Representative's Authority