Acknowledgment of HIPAA Notice of Privacy Practices and Patient Demographics

Name _____ Today's Date _____

Social Security # _____ Date of Birth _____

Address _____ Home Phone ( ) _____

_____ Cell Phone ( ) _____

Occupation _____ Work Phone ( ) _____

Employer _____

Employer Address _____

Marital Status (circle) Single Married Widowed Divorced Other

Spouse's or Partner'sl Name _____ Home Phone ( ) _____

Social Security # _____ Cell Phone ( ) _____

Occupation _____ Work Phone ( ) _____

Employer Address _____

IN CASE OF EMERGENCY, PLEASE NOTIFY:

Name _____ Relation _____

Address _____ Phone ( ) _____

Primary Care Physician: _____

Who referred you? _____

ACKNOWLEDGMENT AND CONSENT: (please fill out completely)

1. I acknowledge that I have received the HIPAA notice of Privacy practices from this office.

Signature _____

2. I consent to receive communication from this office by the following:

***** MARK ALL THAT APPLY WITH AN X*****

Home Phone _____ Work Phone _____ Cell Phone _____ Partner's Work Phone _____

3. The doctors will ASSUME consent for communication online if the patient initiates an E-mail on www.mdhub.com. We assume consent for communication by mail at the address given above. We ASSUME consent to contact you by postcard for reminders of appointments. Please tell us in the space here if you DO NOT want us to contact you In any of these ways: _____

4. I wish to give special permission to release all medical Information at any time to a family member or friend(s) as listed below: _____

RE /HIPPA