Consults in Hypertension, P.A.
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Acknowledgement of the Receipt of Privacy Practices

Patient name _____ Date of birth _____

My signature below confirms that I was provided with, and offered review at any time, the Consults in Hypertension, PA, Notice of Privacy Practices. Included is a copy of the HIPAA guidelines being followed to safeguard my confidential health information.

It also confirms my consent to the use and disclosure of my protected health information for treatment, payment, and health care operations.

My confidential health information may be communicated to me via:

Phone _____ OK to leave a detailed message? _____
Alternative phone _____ OK to leave a detailed message? _____
Email _____
Postal Mail _____

My confidential health information may be shared with these trusted persons:

_____ Relationship to you _____ Phone _____
_____ Relationship to you _____ Phone _____
_____ Relationship to you _____ Phone _____
_____ Relationship to you _____ Phone _____

Acknowledgement of Billing Practices

My signature below authorizes my insurance benefits be paid directly to Consults in Hypertension, PA, and that I am personally responsible for any remaining balance.

Signature _____ Date _____

Printed Name _____