Contemporary Women's Care

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PATIENT NAME: _____ DOB: _____

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices of Contemporary Women's Care.* Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information and your rights related to the use and disclosure of your protected health information. We encourage you to read it in full.

Our *Notice of Privacy Practices* is subject to change. If changes are made, a notice will be posted in the office and on our website. You may obtain a copy of the revised notice at any time.

If you have any questions about our *Notice of Privacy Practices*, please contact:

Contemporary Women's Care 6020 W Parker Suite 330, Plano, Texas 75093. Tel: 469-367-0225

I acknowledge receipt of the *Notice of Privacy Practices* of *Contemporary Women's Care.*

SIGNATURE, CONSENT AND AGREEMENT:

By signing below, I am indicating that I have read and understand this form. I have had the opportunity to ask questions and my questions have been answered to my satisfaction. I understand and agree with the information contained in this form regarding the following (pages 1-12 of this document):

1. Consent for General Treatment
2. Legal Irrevocable Assignment of Benefits and Release of Medical and Summary Plan Documents
3. Consent to Email and /or texting
4. Consent for Photography
5. Financial Policy
6. HIPAA Notice of Privacy Practice, Acknowledgement of Consent

I hereby give my consent to Contemporary Women's Care, P.A. its Physician(s), and Nurse Practitioner or their designee(s). I am either the patient or have the authority to give consent for the patient.

Patient Name: _____

Patient Signature/Date _____

Legal Guardian Signature (if applicable): _____