
805 Columbia Rd. Suite 105
Westlake, Ohio 44145
440-250-0696

# HIPAA Acknowledgement form

- I acknowledge that I have received a copy of the Notice of Privacy Practice provided by Regina Hill M.D. Inc.
- I acknowledge that I have read, understand and agree to the Financial Policy.
- I understand that charges are to be pain in Full at the time of service and that applicable copayments, co-insurances and deductibles are my responsibility.

I authorize Regina Hill M.D. Inc. to discuss my health information with the following persons:

Spouse: _____

_____

Children: _____

_____

Parent(s): _____

_____

Other: _____

_____

Patient Name: _____

Patient Signature: _____

Date: _____