2919 West Swann Avenue, Suite 105B
Tampa, FL 33609
Phone: 813-870-1747
Fax: (813) 343-6089

SOUTH TAMPA CARDIOLOGY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES – (HIPAA)

I acknowledge and agree that I have recived a copy of South TampaCardiology's Notice of Privacy Practices.

_____ _____
Patient signature Date

_____
Print Name of Patient Last First Middle

_____ _____
Email Address Date

_____ _____
Print Name of Legal Representative Relationship to Patient

PATIENT INFORMATION

Address of Patient _____ City_____

State _____ Zip Code _____ Phone _____ Sex _____

Social Security Number _____ Birth Date _____ Age ____ Marital Status_____

Patient Employer_____Occupation_____

Business Phone _____ Business Address_____

Emergency Contact _____ Phone _____ Relationship _____

Primary Insurance Holder's Name _____

Relationship to patient _____ Social Security Number _____

Date of Birth _____ Employer _____ Employer Phone _____

Insurance Company _____ Insurance Phone Number _____

ID Number _____ Group Number_____

Secondary Insurance Holder's Name_____

Relationship to patient _____ Social Security Number_____

Date of Birth_____Employer_____

Insurance Company _____ Insurance Phone Number_____

ID Number _____Group Number_____