Acknowledgement 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's 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? ____

ACKNOWLEDGEMENT 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:

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