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

I acknowledge and agree that I have received a copy of Southern Oregon Cardiology's Notice of Privacy Practices.

Patient signature _____ Date _____

Print Name of Patient Last First Middle

Patient Legal Representative (if applicable) 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 _____