

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

\_\_\_\_\_  
Month\_\_\_\_\_  
Day\_\_\_\_\_  
Year**COMMUNICATION****Appointment Notifications and Reminders****Email**

You can opt to receive emails to keep you informed of new bookings, changes to your bookings, and reminders for upcoming appointments.

- ☐ I would like email notifications of new, cancelled, and rescheduled appointments
- ☐ Email 2 days before appointment

**Text Message (SMS)**

Standard messaging & data rates may apply, messaging frequency can vary and you can update your preferences anytime.

- ☐ Text Message (SMS) 2 hours before appointment

**HIPAA CONSENT FORM****HIPAA Acknowledgement**

Please initial that you have read: \_\_\_\_\_

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

You have the right to revoke this consent at any time by giving this office written notice of your revocation. Please understand that we could no longer file insurance claims for you and that it will not affect any action we took in reliance on this consent prior to receiving your revocation and that we may decline to treat or continue treating you if you revoke this consent.

\_\_\_\_\_ I acknowledge a copy of this office's Notice of Privacy Practices is available to me at my request.

\_\_\_\_\_ I hereby authorize payment to this practice of the insurance benefits otherwise payable to me and recognize and accept personal responsibility of any remaining balance.

Please check the following that apply:

- ☐ OK to leave a message regarding appointment, insurance information, call back requests, etc. on my home phone and/or cell phone.
- ☐ OK to leave a message regarding appointment, insurance information, call back requests, etc. with a family member.
- ☐ OK to leave a message regarding appointment, insurance information, call back requests, etc. on my work phone.

\_\_\_\_\_  
Signature \*\_\_\_\_\_  
Date