Primary Insurance: Group # _____

Name of Insured: _____

Insured's Birth Date: _____ ID# _____

Insured's Address: _____

_____

Insured's Employer Name: _____

Relationship to Insured: _____ self _____ Spouse _____ Child _____ Other

Insurance Plan Name: _____

Insurance Address: _____

_____

Insurance Phone Number: _____

Secondary Insurance: Group # _____

Name of Insured: _____

Insured's Birth Date: _____ ID# _____

Insured's Address: _____

_____

Insured's Employer Name: _____

Relationship to Insured: _____ self _____ Spouse _____ Child _____ Other

Insurance Plan Name: _____

Insurance Address: _____

_____

Insurance Phone Number: _____

HIPAA Privacy Notice

Patient Name: _____

I have received a copy of this office's Notice of Privacy Practices.

Signature: _____ Date _____

For Office Use Only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communications barrier prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (Please Specify)