

HEART AND VASCULAR ASSOCIATES, LLC
130 WESTMOUNT DRIVE, FARMINGTON MO 63640
PHONE 573-756-1818 FAX 573-756-1868

Patient Name: _____

D.O.B.: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received or I have been provided the opportunity to receive a copy of the "Notice of Privacy Practice" that explains when, where, and why my confidential health information may be used or shared. I acknowledge Heart and Vascular Associates, LLC and its staff may use and share my confidential health information with others in order to treat me, in order to arrange for payment of my bill and for issues that concern Heart and Vascular Associates, LLC Clinic operations and responsibilities.

Signature of Patient/Guardian/Parent Relationship of Patient Representative to Patient Date

Signature of Witness Printed Name of Witness Date

Permission to Contact and Release of Information

In order to improve communications between the office and our patients, an automatic service may be utilized to confirm your appointment. Please check the following options below to receive your confirmation call:

Please contact me at: Home Cell Work

You may leave me a message at: Home Cell Work

I prefer to be contacted in the: Morning Afternoon Evening
 8 am – 12 pm 12 pm – 4 pm 4 pm – 6 pm

There may be times when we need to speak to you personally regarding your appointment, to confirm your appointment, or to discuss your confidential health information. Please provide how and where you would like to be contacted. Please check the boxes below to indicate your preference.

Please contact me at: Home Cell Work

_____ I request that you leave a message on my voicemail but only to indicate you have called and I will return your call.

_____ You may at any time release my confidential health information to: (If no names are listed, we will not release any information.)

Name Relationship to Patient Phone Type Phone Number

Name Relationship to Patient Phone Type Phone Number

Name Relationship to Patient Phone Type Phone Number

Signature of Patient/Guardian/Parent Printed Name Date