HEART AND VASCULAR ASSOCIATES, LLC
130 WESTMOUNT DRIVE, FARMINGTON MO 63640
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 Baxter Regional APRN 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 or to leave messages regarding test results. Please check the following options below to receive your confirmation call:

_____ Phone reminders – Contact phone number _____

_____ Text reminders – Contact number _____

_____ Email Reminders* - Email address _____
*You must be registered with our E.H.R. Portal to utilize under HIPAA

Please note, patients who fail to keep appointments or fail to cancel appointments with 24-hour notice will be charged a $50 No Show/No Call fee for visits and testing and $100 for imaging stress tests. Appointments are in high demand, and your notice of cancellation allows us to give another patient access to timely medical care. If you need to cancel your appointment, please call 573-756-1813. If you do not reach a receptionist, please leave a detailed message on the voice mail or send a message through the portal.

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.

_____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 speak with those below or 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

_____

Signature of Patient/Guardian/Parent | Printed Name | Date