Cardio-Thoracic & Vascular Surgical Associates
INFIRMARY HEALTH

Acknowledgement of Receipt of Privacy Practices (HIPAA)

You acknowledge that you were offered a copy of our Notice of Privacy Practices. If you would like to receive a paper copy at any time in the future, you can call (251) 471-3544.

_____ ____/____/____
Patient Name (please print) Date

_____
Signature

If the patient is unable to sign, please indicate the reason why:

_____ Admitted directly to treatment area
_____ Left AMA or without being seen
_____ Unresponsive
_____ Not competent (POA signed)
_____ Refused to sign
_____ Patient is a minor (Guardian signed)

Please list anyone with whom we can speak with about your account:

	Name	Relationship	Medical?	Billing?
1.	_____	_____	□Y □N	□Y □N
2.	_____	_____	□Y □N	□Y □N
3.	_____	_____	□Y □N	□Y □N
4.	_____	_____	□Y □N	□Y □N

FOR OFFICE USE ONLY

_____ _____/_____/_____
Facility Representative Date

90649