CONFIDENTIAL PRACTICE MEMBER PROFILE

Name________________________________ Age________ D.O.B.___/___/___

Address____________________________________City_______

State__________Zip ______ Phone(H)____________________0)____________

Email address:____

Name of Spouse______________________________

By whom were you referred to our office___________________________________

Privacy policy:

As of April 13, 2003 our practice is required by law to maintain the privacy of your health information and provide you with this Privacy Notice. State law may require our practice to grant greater access/restrictions on the use of your Health Information then required by federal law. We are required to abide by the terms of this Privacy Notice. We reserve the right to change the terms of this Notice and to make new provisions effective for all you Health Information. We will distribute and revised Privacy Notice to you prior to implementation. We will not retaliate against you for filing a complaint.

By signed below, I acknowledge receipt of a copy of this Notice and my understanding and my agreement to its terms.

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Signature Date

We will bill the insurance as per your request, but you are responsible for any remaining balance that your insurance company states. We cannot guarantee coverage stated and if your third party doesn't pay as expected, we will bill according to our same-day cash plan. This includes any deductibles and co-pays.

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Signature