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**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES – (HIPAA)**

I acknowledge and agree that I have received a copy of Southern Oregon Cardiology's Notice of Privacy Practices.

\_\_\_\_\_  
Patient signature \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
Print Name of Patient Last First Middle

\_\_\_\_\_  
Patient Legal Representative (if applicable) Date \_\_\_\_\_

\_\_\_\_\_  
Print Name of Legal Representative Relationship to Patient \_\_\_\_\_

**PATIENT INFORMATION**

Address of Patient \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone \_\_\_\_\_ Sex \_\_\_\_\_

Social Security Number \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Marital Status \_\_\_\_\_

Patient Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Business Phone \_\_\_\_\_ Business Address \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Primary Insurance Holder's Name \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Social Security Number \_\_\_\_\_

Date of Birth \_\_\_\_\_ Employer \_\_\_\_\_ Employer Phone \_\_\_\_\_

Insurance Company \_\_\_\_\_ Insurance Phone Number \_\_\_\_\_

ID Number \_\_\_\_\_ Group Number \_\_\_\_\_

Secondary Insurance Holder's Name \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Social Security Number \_\_\_\_\_

Date of Birth \_\_\_\_\_ Employer \_\_\_\_\_

Insurance Company \_\_\_\_\_ Insurance Phone Number \_\_\_\_\_

ID Number \_\_\_\_\_ Group Number \_\_\_\_\_