estd. 2018

HOMETOWN
CONCIERGE HEALTH

in-home family medicine

NOTICE OF PRIVACY ACTS

I hereby acknowledge that I have been presented a copy of Hometown Family Care Associates, L.L.C's Notice of Privacy Practices.

Patient Signature: _____

Relationship (Circle): 1. Self 2. Parent 3. Guardian

Date: _____

In order to protect your privacy, we ask that you complete the following section, which will enable us to better serve you in the future. Please write your initials beside each statement. We also ask that you enter the name of each person you would like to have access to your account (You will need to list your spouse) (Parents of minors are already allowed health information). Also, please sign and date the bottom of the form. This form may be updated at any time. Thank you for your cooperation.

_____ (initial) I authorize the office of Hometown Family Care Associates, LLC to leave information regarding my appointments and/or account information on text messages/voicemail/answering machine.

_____ (initial) I authorize the office of Hometown Family Care Associates, LLC to leave information regarding normal labs and test results on text messages/voicemail/answering machine.

I authorize the office of Hometown Family Care Associates, LLC to speak with the following people regarding my insurance coverage, financial account, appointments, lab and test results, and course of treatment.

Name: _____ Relationship: _____ Date of Birth:_____

Name: _____ Relationship: _____ Date of Birth:_____

Name: _____ Relationship: _____ Date of Birth:_____

Signature: _____ Print Name: _____ Date: _____

HT Family Care Associates, LLC

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