

Please fill out this form COMPLETELY, write N/A where applicable and sign it. Thank you.

Policy Holder Information	Policy Holder Information
First Name: _____ Last Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Policy Holders SS# _____ Policy Holders Date of Birth: _____ Gender: ☐ Male ☐ Female Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other	First Name: _____ Last Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Policy Holders SS# _____ Policy Holders Date of Birth: _____ Gender: ☐ Male ☐ Female Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

By signing below, I acknowledge that I have been given the opportunity to review the Health Insurance Portability and Accountability Act (HIPPA) Notice of Privacy and agree to comply with all of its terms.

Today's Date: _____ Patient's Signature: _____