Clayton L. Moliver, M.D., P. A.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient Name: _____

Date of Birth: _____

Social Security Number: _____

I acknowledge that Clayton L. Moliver, M.D., P. A. provided me with a written copy of the Practice Notice of Privacy Practices.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

You may be contacted by the office of Clayton L. Moliver, M.D., to remind you of any appointments, healthcare treatment options or other health services that may be of interest to you.

May we contact you at home? Yes No (circle one)
May we contact you at work? Yes No (circle one)
May we contact you via cell phone? Yes No (circle one)
May we leave a voice mail at all of the above? Home: Yes No
Work: Yes No Cell: Yes No
May we contact you via email? Yes No
If "Yes", may we send you special offerings via email? Yes No
Can a message be left using our name and what the call is in reference to? Yes No

Is there anyone we can leave a message with? Yes No (If yes, please list names)

_____ _____

Would you like to authorize an individual as your personal representative? This person would have the authority to schedule, confirm or change appointments only.
Yes No (If yes, please list first and last name)

_____

_____ _____
Patient Signature Date

_____ _____
Personal Representative Signature (if applicable) Relationship to Patient