# ACKNOWLEDGE FORM FOR
# HIPAA NOTICE OF PRIVACY PRACTICES

Custom Family Care.
Ivan Pivovarov, MD
279 Hughes Road, Madison, Al. 35758
(256) 325-0480

By signing below, I hereby acknowledge receipt of the privacy notice for Custom Family Care.

_____ _____
Printed Name of Patient Date

_____
Signature of Patient or Patient's Representative

_____
Printed Name of Patient's Representative (if applicable)

_____
Representative's Relationship to Patient (if applicable)

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To be completed by Custom Family Care.

After a good faith attempt to obtain an Acknowledgement of receipt, the patient or representative Refused or was unable to sign the Privacy Notice for the following reason(s) _____
_____
_____
_____

_____ _____
Signature of Custom Family Care Representative Date

Custom Family Care
Ivan Pivovarov, MD
279 Hughes Road, Madison, AL 35758
(256) 325-0480

# Consent For Treatment and Release of Information

The following information is to be completed by the patient or the patient's legally authorized representative/parent:

I consent to medical treatment for myself or for the patient for whom I am parent or legally authorized representative. I understand that Custom Family Care will share patient information according to federal and state law for treatment, payment, and operations.

I consent to release my health information to:

Name:_____ Phone:_____ Relationship:_____

I understand that the patient is responsible for all charges incurred, regardless of the patient's insurance status. The patient agrees to pay for services as the patient incurs the charges. I authorize the insurance provider to pay Custom Family Care for services rendered.

Signature of Patient: _____ Date: _____

Signature of Legally Authorized Representative: _____

Relationship of Legally Authorized Representative to Patient: _____

Date: _____

## PATIENT DEMOGRAPHIC FORM

Patient First Name:_____ Last Name:_____

Date of Birth:_____ SSN:_____ Gender:_____

Home Address: Street_____

City_____ State_____ Zip Code_____

Phone: home ( _____ ) ____ -_____ cell ( ____ ) ____ -_____ work ( ____ ) ____ -_____

Marital Status: married___ single___ divorced___ separated___ widowed___

Language (other than English):_____ Race_____ Ethnicity_____

Reason for visit:_____ Preferred Pharmacy with Address: _____

How did you hear about us:_____ Email _____

## PRIMARY INSURANCE

Ins Co Name_____ Policy/Member ID#_____ Group ID#_____

Patient relation to insured: self____ spouse____ child___ other_____

Policy Holder:_____ Gender_____

Home Address: Street_____

City_____ State_____ Zip Code_____

Phone: home ( ____ ) ____-_____ cell ( ____ ) ____-_____ work ( ____ ) ____-_____

Date of Birth:_____ Employer_____

## SECONDARY INSURANCE

Ins Co Name_____ Policy/Member ID#_____ Group ID#_____

Patient relation to insured: self____ spouse____ child___ other_____

Policy Holder:_____ Gender_____

Home Address: Street_____

City_____ State_____ Zip Code_____

Phone: home ( ____ ) ____-_____ cell ( ____ ) ____-_____ work ( ____ ) ____-_____

Date of Birth:_____ Employer_____