Clermont Internal & Cosmetic Medicine
290 Citrus Tower Blvd, Suite 102
Clermont, Florida 34711
Phone: 352-404-5174 Fax : 855-794-3370

HIPAA – PATIENT ACKNOWLEDGEMENT FORM

I, _____, hereby acknowledge receipt of the Clermont Internal & Cosmetic Medicine (CICM)'s Notice of Privacy Practices. The Notice of Privacy Practice Practices provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved the right to change his privacy practices that are described in the Notice. I also understand that a copy of any revised Notice will be provided to me or made available from the office website at www.ClermontInternalMedicine.com.

I authorize release of any medical information necessary to process insurance claims and payment of medical benefits directly to CICM.

I understand that my insurance company may not cover services due to reasons such as: lack of coverage, non-covered services, etc. If my insurance company denies payment, I agree to be personally and fully responsible for payment of all charges.

I DO ❑ - I DO NOT ❑ request a chaperone in the exam room during the physical portion of my examination at CICM.

I authorize CICM's staff to discuss my medical treatment with: (check as applicable) Only myself ❑

OR Myself and the following:

Doctor/Name:_____Phone:_____Address: _____

Name:_____Relationship:_____Phone:_____Address:_____

I prefer to be contacted by a phone call to: Home ❑ Cell ❑ Work ❑ Phone #:_____

Messages may be left on my answering machine or voicemail: Yes ❑ No ❑

Messages may be left with one of the people listed above: Yes ❑ No ❑ Whom?:_____

EMERGENCY CONTACT: NAME_____ PHONE:_____RELATIONSHIP:_____

All mail will be sent to your home address and no health information will be faxed to you without your permission.

Signed: _____ Date: _____