

For Office Use Only:
Account # _____

Patient Acknowledgement & Consent Form

Consent to Release Information:

Protected Health Information (including billing information) of the patient *may be released* to the following individual(s):

1. _____
2. _____
3. _____

Patient or Parent/Guardian Signature: _____ Date: ____/____/____
(No signature is required if no one is listed above)

Payment and Privacy:

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE: I understand that Femme Care, Inc. may release information from my medical and/or billing records in accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPAA) and statutory regulations of the Commonwealth of Virginia. My signature below acknowledges that I have either received or had an opportunity to review a copy of Femme Care, Inc.'s Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed regarding my protected health information.

By signing this document, I am affirming that I am the patient or the legal custodian of the patient (or have provided written authorization from the legal custodian to seek medical treatment for patient), that all information supplied is accurate, that I have received, read or had read to me, and fully understand each of the above sections that I have checked. I affirm that I have had the opportunity to review a notice of privacy practices from Femme Care, Inc., and that I have reviewed and signed Femme Care, Inc.'s financial agreement. Finally, I authorize Lisa J. Roberts, CNM and Femme Care, Inc. to provide medical care.

Patient or Parent/Guardian Signature: _____ Date: ____/____/____

Witness: _____ Date: ____/____/____