Generations Primary Care, LLC
NEW PATIENT REGISTRATION FORM

Office Phone Number and Extensions
(205) 343-6979

Press option #1 to reach Dr. Keisha Lowther's scheduler/administrative assistant
Press option #2 to reach Dr. Jamie Lowther's scheduler/administrative assistant
Press option #3 to reach the Nurse's desk for rx/labs/imaging referrals
Press option #4 to reach the Office Manager/referral coordinator/accounts payables
Be sure to visit our patient portal to carry out many actions, visit www.generationspc.com

HERE IS SOME HELPFUL INFORMATION ON THE NEW PATIENT REVIEW PROCESS

1. Complete the registration forms (all five pages) and return to our office. You may return forms...
   in person or via mail 6531 Hwy 69 South Suite A Tuscaloosa, AL 35405
   via email to robinsv@generationspc.com
   via fax (205) 345-3343

2. Your registration form will be reviewed, and upon acceptance a scheduler will contact you with a new patient appointment. Please know there are specific times made available for patients first appointment, as they require additional time. In the event, we cannot accept you as a patient, we will contact you to advise such.

3. Immunization records for pediatrics patients MUST be received by our office PRIOR to patients being seen for their appointment. You may bring the immunization record the day of scheduled new patient appointment.

Thank you for choosing Generations Primary Care, LLC. And entrusting us with your health care needs. Please know we do not take your choice for granted. We are dedicated to bringing the best healthcare and medical knowledge to you by providing quality patient care. By choosing our facility and physicians, you have become a partner with us in pursuing the most appropriate and medically advances treatment available to you today.

-Physicians and Staff at Generations Primary Care, LLC.

Generations Primary Care, LLC

NEW PATIENT REGISTRATION FORM

6531 Hwy 69 South Suite A
Tuscaloosa, Alabama 35405
ph (205) 343-6979 fax (205) 345-3343
www.Generationspc.com

Today's date: ____/____/____
How did you hear about us?_____
_____

___ I am requesting Dr. Keisha Lowther as my Primary Care Physician
___ I am requesting Dr. Jamie Lowther as my Primary Care Physician
___ No preference, either Dr. Keisha Lowther or Dr. Jamie Lowther

PATIENT DEMOGRAPHICS

***Please enter your legal name. Incomplete forms will not be accepted.

Patient Last Name: _____ First Name: _____ Middle Name:_____

Date of Birth: _____/_____/_____ Age: _____ Social Security Number: _____-_____-_____ Gender: Male or Female

Race: _____ Marital Status: Single / Married / Divorced / Separated / Widowed

Street Address: _____ City: _____ State: _____ Zip: _____

Cell Phone Number (___) ___-_____ Home Phone Number (___) ___-_____ Work Phone Number (___) ___-_____

Email address: _____@_____._____

INSURANCE INFORMATION

Name On Policy/Guarantor: _____ Relationship to Patient: _____ Birth date: ____/____/___

Address (SKIP, if it is the same as patient's, complete if it is different) Is this individual a patient here: ____Yes ____No

Street Address: _____ City: _____ State: _____ Zip: _____

Cell Phone Number (___) ___-_____ Home Phone Number (___) ___-_____ Work Phone Number (___) ___-_____

Occupation: _____ Employer: _____ Employer's Phone Number: (____) ____-_____

Employer Address _____ City: _____ State: _____ Zip: _____

Insurance Company: _____ Policy Number: _____ Group Number: _____

Secondary Insurance Company: _____ Policy Number: _____ Group Number: _____

Name On Policy/Guarantor: _____ Relationship to Patient: _____ Birth date: ____/____/____

IN CASE OF EMERGENCY

Name of relative or friend (not at the same address): _____

Cell Phone Number (___) ___-_____ Home Phone Number (___) ___-_____ Work Phone Number (___) ___-_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Generations Primary Care or insurance company to release any information required to process my claims.

Parent/Guardian Signature _____ Date _____/_____/_____

Generations Primary Care, LLC

NEW PATIENT REGISTRATION FORM

Today's date: ____/____/____ Last Name: _____

Please list any other names you may be listed as: _____

What is the reason for your visit? _____ _____

_____

Do you have children? Yes or No Are they healthy? Yes or No

Employment: ___Full-Time ___Part-Time ___Retired ___Disabled ___Homemaker

Occupation: Type of Work/Jobs: _____

Habits:

Do you smoke? ___Yes ___No If yes, how many packs per day? _____
If you have quit, how long ago? _____

Do you use alcohol? ___Yes ___No If yes, how often do you drink? _____
If you have quit, how long ago? _____

Do family or friends worry about your alcohol intake? ___Yes ___No

Have you ever had problems with drug use? ___Yes ___No

Do you use your seatbealts? ___Yes ___No

MEDICAL HISTORY

Please list other diseases from which you currently suffer (heart, lung, etc.):

_____

_____

Please list other medical conditions from which you have suffered in the past:

_____

_____

Please list any surgeries (operations), reason for the surgery, and date of surgery:

_____

_____

Transfusions: Have you ever received a blood transfusion? ___Yes ___No When? _____

ALLERGIES

ALLERGIES OR ADVERSE DRUG REACTIONS: Please list drug and type of reaction.

_____

_____

_____

Generations Primary Care, LLC

NEW PATIENT REGISTRATION FORM

Today's date: ____/____/____ Last Name: _____

MEDICATIONS

Prescription Medication	Dose	How Often Taken

NON-PRESCRIPTION (over-the-counter medications) such as aspirin, ibuprofen, vitamins, laxatives, etc.

Over-the-counter Medications	Dose	How Often Taken

FAMILY HISTORY

Place an "X" in appropriate boxes to identify all illnesses/conditions in your blood relatives

Illness/Condition	Family Member							
	grandparents	father	mother	brother	sister	son	daughter	other
Heart Disease								
Diabetes								
High Blood Pressure								
High Cholestorol								
Breast Cancer								
Colon Cancer								
Other Cancers								
Alcohol/Drug Abuse								
Depression/Psychiatric Illness								
Genetic (inherited) Disorder								
Other								

Generations Primary Care, LLC

NEW PATIENT REGISTRATION FORM

Today's date: ____/____/____ Last Name: _____

SYMPTOM REVIEW

GASTROINTESTINAL
- __ Poor appetite
- __ abdominal pain
- __ indigestion
- __ trouble swallowing
- __diarrhea
- __constipation
- __ change in bowel habits
- __ nausea or vomiting
- __ rectal bleeding or blood in stools
- __ history of liver disease or abnormal liver tests

CARDIOVASCULAR
- __ chest pain
- __ history of angina or heart attack
- __ history of high blood pressure
- __ history of irregular heart beat
- __history of poor circulation

PULMONARY/LUNGS
- __ shortness of breath
- __ persistent cough
- __coughing up blood
- __ asthma or wheezing

MUSCLE/JOINT/BONE
- __ swelling of ankles or legs
- pain, weakness or numbness in...
- __ arms or hands
- __ back or hips
- __ legs or feet
- __ neck or shoulders

NEUROLOGIC
- __ history of stroke
- __ blackouts or loss of consciousness

Anything else?
- __ Experiencing an unusually stressful situation?

GENERAL
- __ weight gain/loss of 10+ lbs during the last 6 mos
- __ poor sleep
- __ fever
- __ headache
- __ depression

EYES, EARS, NOSE, THROAT
- __ blurred vision
- __ other change in vision
- __ history of glaucoma or cataracts
- __ loss of hearing
- __ ringing in ears
- __ sinus problems
- __ hoarseness

GENITOURINARY
- __ frequent or painful urination
- __ blood in urine

SKIN
- __ itching
- __ easy bruising
- __ change in moles

ENDOCRINE
- __ history of diabetes
- __ history of thyroid disease
- __ change in tolerance to hot or cold weather
- __ excessive thirst

WOMEN ONLY
- __ abnormal Pap Smear
- __ bleeding between periods
- date of last period _____
- date of last mammogram _____

MEN ONLY
- ___ PSA

IMMUNIZATIONS: If YES, give approximate year given

Pneumococcal	___Yes	In what year? _____	___No, I have not
Hepatitis A	___Yes	In what year? _____	___No, I have not
Hepatitis B	___Yes	In what year? _____	___No, I have not
Tetanus	___Yes	In what year? _____	___No, I have not

MEDICAL APPOINTMENT CANCELLATION POLICY

Dear Patient,

To give all our patients the best possible care, please respect the time we allow for each appointment.

If you need to cancel your appointment we ask that you cancel at least **24 hours prior** to the scheduled time. You must notify our office within 24 hours of your appointment or you will be charged **$50.00**. This policy also applies to not showing up for your scheduled appointment.

As a courtesy, when time allows, we may make a reminder call for your appointment. An automated call reminder system upgrade is in the works, but for now we suggest you enter your appointments on your calender, your electronic devises or place your appointment card in a visible area.

Thank you for trusting your medical care to Generations Primary Care. We strive to render excellent medical care to you, your family, and all of our patients.

I have read and understand the Medical Appointment Cancellation Policy and agree to be bound by it's terms.

_____	_____
Signature	Relationship to Patient
_____	_____
Printed Name	Date

Generations Primary Care

providing comprehensive healthcare for every member of your family

PATIENT FINANCIAL RESPONSIBILITY

Thank you for choosing Generations Primary Care for your medical needs. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities:

- The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care including labs and testing.
- We will bill your insurance for you. However, the patient is required to provide the most correct and updated information regarding insurance.
- Patients are responsible for payment of co-pays, coinsurance, deductibles, and all other procedures or treatment not covered by their insurance plan.
- Co-pays are due at the time of service.
- Coinsurance, deductibles, and non-covered items are due 30 days from receipt of billing.

Patients may incur, and are responsible for payment of additional charges, if applicable. These charges may include:

- Bluecard: $10.00 (there is NO charge when requested at the time of patients office visit)
- FMLA Paperwork: $50.00
- Disability Forms: $50.00
- No-show fee: $50.00
- Sports physicals: $30.00

By my signature below, I hereby authorize assignment of financial benefits directly to Generations Primary Care and any associated healthcare entities for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment.

_____

Patient Name (please print)

_____

Patient/Guardian Signature

_____

Date

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providing comprehensive healthcare for every member of your family

RELEASE OF INFORMATION

If you anticipate the need for anyone else to have access to protected health information about you, please complete the information below.

I, the undersigned patient and/or responsible party, hereby authorize Generations Primary Care, it's physicians, agents, employees, or representatives to discuss or release any or all patient information about me including, but not limited to, past and current medical information, billing information, appointment scheduling, prescriptions, etc. to the person or persons indicated below:

NOTE: Patients 14 years and older MUST be the one to sign this form.
If you DO NOT want anyone to have access to your records, please put an "X" through the boxes and sign.

NAME	RELATIONSHIP TO PATIENT	PHONE

_____ _____
Patient Name (please print) Patient/Guardian Signature

_____
Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient's Name: _____
I have been given a copy of Generations Primary Care's Notice of Privacy Practices.

_____ Date: _____
(Signature of patient/legal representative)

If you are the legal representative of the person list above, please note the basis for your authority and provide appropriate documentation:
___Power of Attorney ___Parent of Minor

___Guardianship Order ___Other_____

Generations Primary Care
providing comprehensive healthcare for every member of your family

INFORMATION AND POLICIES

Thank you for your interest in our services. In order to make your transitions to our practice as simple as possible there are policies that you will need to read and sign. We look forward to serving you as our patient. We prefer good quality medical care for you and your family. Please make every effort to establish with a provider a standard routine for medical care appropriate for your age and medical history. We are familiar with up-to-date quality of care standards for good health care for our patients

Office Hours are from 8am to 4pm Monday thru Thursday with lunch from noon - 1, 8am to noon Friday, 8am to noon select Saturdays . We provide on-call services after hours. In the event of an emergency please call 911. Our patient portal is available 24/7 and many functions are available there, visit generationspc.myspringcharts.com

Prescription requests require 48 to 72 hour notice. Any routine medication refills will be called in during business hours only. We make every effort to provide enough medication/refills to last until the next medically necessary appointment. If a patient has not been seen in an appropriate timeframe an office visit may be required. After hour prescription requests will be called in at the discretion of the provider. No narcotics or controlled substances will be called in. A called in medication may be subject to a **$25** fee.

Appointment cancelation fee Appointments canceled without a 24 hour notice are subject to a **$50** cancelation fee. This charge is not covered by the insurance company, but by you.

Financial responsibility You are ultimately responsible for all charges associated with your care regardless of insurance coverage. Your insurance will be filed as a courtesy. Please be familiar with the term and policies of your insurance plan. If you have a deductible, which has not been met, it will be due at the time of service. If your insurance deems your visit or labs as a noncovered service you will be responsible for the balance. The terms of your insurance policy are between you and your insurance company. Patients are expected to pay all co-pays, co-insurance, and deductibles at the time of service. If you have a high deductible plan, be prepared to pay for your services in full as you incur them. Monthly statements are mailed to each patient family with balance due on receipt. If you fail to pay the balance in full within 30 days, fail to contact the collection department to make payment arrangements, or fail to pay after making agreed upon financial arrangements, your account may be sent to an outside collection agency. You will be responsible for fees assessed by the collection agency. This outstanding debt may also be listed with local, regional, or national credit-reporting agencies and may have a negative effect on your credit rating and the granting of future credit.

Financial agreement The undersigned agrees that in consideration for the services rendered to the patient, he/she individually agrees to be totally responsible for all charges for services rendered and associated fees. The undersigned agrees to assign payment for the unpaid charges from the services provided by Generations Primary Care is authorized to bill. The undersigned accept the fee(s) charged as a legal and lawful debt. I understand the fees charged are due at the time of service. Should it become necessary to forward my account for collection, I agree to pay all monies due, including 50% collection fee, attorney fees, and/or court costs, if such be necessary. The undersigned also authorizes the release of any information pertinent to any insurance company, adjuster, or attorney involved in their case. Also authorizing the doctor to initiate a complaint to the Insurance Commissioner for any reason on their behalf.

Medicare Policy As a courtesy our patients, Generations Primary Care accepts Medicare assignment. We will file your claims to Medicare for you and hold billing until Medicare has responded to the claim. Medicare will pay 80% of their allowable, and the patient or their secondary insurance is responsible for the remaining 20%. Your Medicare deductible must be met first. If you supply our office with the correct billing information, we will file with your secondary insurance carrier on a one-time basis. If your secondary insurance carrier does not pay within 60 days, you will be responsible for the balance.

Worker's Compensation, Third party, Auto Insurance Policies These claims are not covered by your regular insurance. Our offices does not do worker's compensation claims. We are not in network with these types of policies. You will be responsible for payment at time of service.

Having read the above, I agree to abide by the policies set by Generations Primary Care.
My signature below confirms by reading and understanding of the Patient Privacy Statement.

Patient Signature _____ Date _____
Print Name _____

Generations Primary Care
providing comprehensive healthcare for every member of your family

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices is being provided to you as a requirement of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes how Generations Primary Care may use and disclose medical information about you to carry out treatment, payment for our health care services and for other health care operations or purposes that are permitted or required by law. It also describes your rights to access and control medical information about you. As a patient of Generations Primary Care, one of the responsibilities you have entrusted to us is the protection of your personal medical information. Our physicians and staff take this responsibility very seriously.

The uses and disclosures listed below may be limited by Alabama Requirements described under Regulatory Requirements.

Uses and Disclosures of Protected Health Information (PHI) for Treatment, Payment and Health Care Operations
The following describes the different ways that we Generations Primary Care may use and disclose your PHI for treatment, payment and health care operations.
For Treatment – We may use PHI about you to provide you with medical treatment or services. For example, we may disclose your PHI to doctors, nurses, technicians, training doctors, or other health care professionals who are involved in taking care of you.
For Payment – We may use and disclose PHI about you so that the treatment and services you receive may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may disclose your PHI to your insurance company so that they will pay for our services rendered to you.
For Healthcare Operations – We may use and disclose your PHI for health care operations. Some of these operations include the use or disclosure of your PHI for quality improvement, doctor/employee review activities, compliance, and the training of medical residents and other health care professionals, which includes preceptorships for health care affiliates. For example, we may compare the treatment you received to other similar episodes of care to ensure that Generations Primary Care continues to provide the highest quality services.

Business Associates
We may disclose PHI to “business associates”, who perform services on behalf of our practice. Some examples of our business associates are transcription services, collection agency, and call answering service. Whenever an arrangement between our Practice and a business associate involves the use or disclosure of your PHI, we will have a written contract with that business associate that will protect your privacy.

Uses and Disclosure of Protected Health Information (PHI) Based upon Your Written Authorization
Other uses and disclosures of PHI not covered by this notice or the laws that apply to our Practice (described below) will be made only with your written permission. If you provide us permission to use or disclose your PHI, you may revoke that permission, in writing, at any time. If you revoke your permission, thereafter we will no longer use or disclose PHI about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission.

Uses and Disclosures That May Be Made With Your Agreement or Opportunity to Object
Unless you object, we may disclose some of your PHI to a family member, other relative, friend, or other persons you identify. We may also notify these people about your location and condition. When you are unable to agree or object, we may still disclose your PHI for these purposes in certain circumstances.

Other Permitted and Required Uses and Disclosure That May Be Made Without Your Authorization
In addition to using and disclosing your PHI for treatment, payment and health care operations, we may use or disclose your PHI without your written authorization in the following situations:
• As required by law: We may use or disclose your PHI when required to do so by applicable law. For example, in certain circumstances, we may also disclose PHI to report about an individual that we reasonably believe to be a victim of abuse, neglect, or domestic violence.
• For public health purposes.
• For health oversight activities authorized by law : We may disclose your PHI to the government for oversight activities, such as audits, I investigations, inspections, licensure and disciplinary actions, and other activities necessary for monitoring the health care system.
• For Workers’ Compensation claims. (These programs provide benefits for work-related injuries or illnesses.)
• To a coroner, medical examiner or funeral director for the purpose of identifying a decedent, determining a cause of death, or as necessary to enable such parties to carry out their duties.
• For cadaveric organ, eye or tissue donations.
• For medical research purposes.
• To prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
• For specialized government functions: In certain circumstances, we may use and disclose your PHI if you are a veteran or in the military. We may also disclose your PHI to authorized federal officials for intelligence and other national security activities, for the protection of the President or others, and for special investigations. If you are an inmate of a correctional institution or under custody of a law enforcement officer, we may disclose your PHI to the correctional facility or official in certain circumstances.

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NOTICE OF PRIVACY PRACTICES

Communication
We may use and disclose your PHI to contact you (by telephone or mail) and remind you of an appointment, or to inform you of treatment alternatives or other health-related benefits and services that may be of interest to you. We may be required to leave a message on your answering machine, when contacting you by telephone to remind you about an appointment, provide instructions prior to a diagnostic test or procedure, or to discuss payment. We may also use and disclose your PHI to encourage you to purchase or use a product or service through face-to-face communication or by giving you a promotional gift of nominal value.

Your Rights Regarding Medical Information About You Right to Inspect and Copy
You have the right to inspect and copy PHI that may be used to make decisions about your care. To inspect and copy PHI, you must submit your request in writing to our Privacy Officer. You will be notified when you record is ready to inspect or copies are completed. If you request a copy of the information, we will charge you a reasonable fee for the cost of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain circumstances.

Right to Amend
If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have a right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing to our Privacy Officer, and it must explain why you are requesting an amendment to your PHI. We may deny your request in certain circumstances. If this request is denied, Generations Primary Care will send you a written letter supporting reason for denial.

Right to an Accounting of Disclosures
You have the right to request an “accounting of disclosure.” This is a list of certain disclosures we have made of your PHI. You must submit your request in writing to our Privacy Officer. Your request must state a time period that may not be longer than six years and not include dates before April 14, 2003. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the cost but we will notify you of this charge before it is incurred to you.

Right to Request Restrictions
You have the right to request a restriction or limitation on the PHI we use or disclose. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to our Privacy Officer. In your request, you must tell us: 1) what information you want to limit; 2) whether you want to limit our use, disclosure or both; and, 3) to whom you want the limits to apply. Any previous restrictions given verbally or written to a Generations Primary Care employee are no longer valid and must be requested in the above manner.

Right to Request Confidential Communications
You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. To request confidential communications, you must make your request in writing to our Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. Any previous requests given verbally or written to a Generations Primary Care
employee are no longer valid and must be requested in the above manner.

Right to a Paper Copy of This Notice
Even if you agreed to receive this notice electronically, you have a right to request a paper copy by writing our Privacy Officer or asking for a copy at the reception/check-in desk at our Generations Primary Care facility.

Regulatory Requirements
We are required by law to maintain the privacy of your medical information, and we must abide by the terms of this notice. (That is, the version that is currently in effect). We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for the medical information we already have about you, as well as any information we receive in the future. We will post a copy of the current notice, with the effective date listed in the bottom right hand corner of the last page. In addition to the privacy protections provided under federal law (which are described in this notice), Alabama law (referred to in this notice as the Alabama Requirements) requires us in certain situations to get your written consent (or, under some statutes or rules, written consent from your attorney, guardian, or upon court order) before we can use or disclose your information.
The Alabama Requirements may apply:
• If you qualify as a patient that suffers from a sexually transmitted disease;
• If you qualify as a patient that receives benefits from the State of Alabama for certain developmental disabilities or mental retardation;
• If you qualify as a patient that the Alabama Medicaid program has asked us to serve as a Case Management Service Provider for;
• If you qualify as a patient that receives rehabilitative services through the Alabama Medicaid program;
• If you qualify as a patient that receives certain benefits under the Alabama Medicaid’s Preventive Health Education program.

Complaints
If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services (or his or her designee). To file a complaint with Generations Primary Care, contact our office manager. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

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providing comprehensive healthcare for every member of your family

CONSENT TO TREAT

A. Consent to Treatment
I authorize the physician at Generations Primary Care and other healthcare providers under the direction of the physician to provide reasonable and proper medical care by today's standards. I understand that no guarantee has or will be made to me regarding any possible result or cure based on my examination and/or treatment.
_____ Initials

B. Assignment of Benefits
I hereby assign all insurance benefits provided by my insurance company directly to Generations Primary Care.
_____ Initials

C. Payment Policy
I understand that I am fully responsible for all charges incurred during care and treatment, regardless of any insurance benefits I may have. I also understand that insurance claims filed by this office for services rendered are being filed strictly a courtesy to me, and in no way releases me of my financial obligation to this office. If my insurance company does not pay the claim within 60 days, I will be fully responsible for the payment. I will provide all necessary assistance to the office to have my claim paid by my insurance company. I understand that if my account balance remains unpaid for a period of 90 days that Generations Primary Care retains the right to institute whatever method necessary to collect the unpaid balance. As the patient and/or Guarantor, I will be responsible for any collection fees, attorney fees, court costs and other expenses incurred in the collection of the unpaid balance. Furthermore, I waive all rights of exemption under the laws of the State of Alabama and any other state.
_____ Initials

D. Notice of Privacy Practices
I acknowledge receipt of the current version of the "Notice of Privacy Practices" of Generations Primary Care, which describes how my Private Health Information (PHI) may be used.
_____ Initials

E. Authorization for Disclosure of PHI
I specifically authorize the following persons to receive my protected health information:

Name _____ Relationship_____ Phone_____

Name _____ Relationship_____ Phone_____

_____ _____
Patient Name (please print) Patient/Guardian Signature

_____
Date