Due to HIPPA regulations - if you are over 18 years of age, please list any authorized person(s) with whom we can discuss your appointments, insurance and or/ payments with (i.e. spouse, parent, etc.)

Printed Name:

Relationship:

Printed Name:

Relationship:

Printed Name:

Relationship:

Can we leave detailed messages with sensitive information if necessary? ☐ **YES** ☐ **NO**

By signing below, you confirm that you have read and understood the above information, notification of privacy policies, and HIPPA.

Signature of patient or Representative:

☐ **I decline to sign** ______________________________

Printed Name:

Date:

Relationship to patient: Self ☐ **Parent** ☐ **Legal guardian** ☐ **Power of attorney** ☐ **other** ☐