CLIENT/PATIENT NAME _____

It may be necessary for the office of Novo: Renewing Joy in Life PC to leave a message for you regarding your treatment

CAN WE LEAVE A MESSAGE ON YOUR:

Home phone: Yes No Number _____
Work phone: Yes. No. Number_____
Cell Phone: Yes. No. Number_____

PLEASE LIST EVERY FAMILY MEMBER OR FRIEND YOU AUTHORIZE TO SPEAK WITH US ABOUT YOUR HEALTH CARE ISSUES. THIS INCLUDES SPOUSE, CHILDREN, PARENTS, OTHERS THAT YOU DESIGNATE.
REMEMBER THAT IF ANYONE CALLS US WITH A QUESTION, WE WILL NOT BE ABLE TO SPEAK WITH THEM UNLESS THEY ARE LISTED HERE.

Name_____ Relationship_____ Phone# _____

Name_____ Relationship_____ Phone # _____

Name _____ Relationship_____ Phone # _____

This will remain in effect until revoked in writing.

EMERGENCY CONTACT:

Name _____ Relationship_____ Phone #_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Novo: Renewing Joy in Life PC Notice of Privacy practices

Client/Patient Signature_____ Date_____

Annual Update vga 12-10-20