Comprehensive Care Center of Irvine

Communicating with You

To effectively communicate with you about your medical and financial needs, we request that you complete this form identifying the best ways to provide you with your confidential information. We may need to communicate test results, prescription information, financial information or respond to a message you left for your physician's office. **We may communicate with you through mail, secure email (Secure Patient Portal), and telephone, including text messages, leaving messages on your answering machine's/voice mail.**

Please check all boxes that give Comprehensive Care Center of Irvine permission to use for your communications:

❑ You may contact me by telephone	Phone Number: _____ ❑ Cell ❑ Home ❑ Work
❑ You may leave a message/voice mail	Phone Number: _____ ❑ Cell ❑ Home ❑ Work
❑ You may contact me through email (Secure Patient Portal)	
❑ You may contact me through secure texting	Cell Phone Number: _____

Please list any persons you would like to have access to your billing, appointment, or health information, such as your spouse, caretaker, or other family member. We will ask for additional consent prior to releasing information related to psychiatric services and/or HIV test results.

Name/Phone Number	Relationship	Options
1.		❑ Billing Information ❑ Appointment Information ❑ Medical/Health Information
2.		❑ Billing Information ❑ Appointment Information ❑ Medical/Health Information

This request supersedes any prior request for communication of information I may have made.

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov

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Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I received a copy of the notice of Privacy Practices for the above medical practice. I further acknowledge that a copy of the current notice is posted in the reception area and that any amended notice of Privacy Practices will be made available at my next appointment.

If not signed by the patient, please indicate:

Relationship:

- Parent or guardian of minor patient
- Legal Guardian or conservator of an incapacitated patient
- Beneficiary or personal representative of deceased patient

Name of Patient: _____

_____ _____ _____

Signature of Patient/Responsible Party | Patient Date of Birth | Todays Date

_____ _____

Name of Patient/Responsible Party (Print) | Relationship to Patient