# Tina Snodgrass Skin Care Practice, PLLC

## NOTICE OF PRIVACY POLICIES AND CONSENTS

**Print Name**_____**DOB**_____

**Personal Representative**
I authorize Tina Snodgrass Skin Care Practice, PLLC to give my personal representative(s), as listed below, protected information on my behalf.

**Personal Representative Name** **Relationship**

_____ _____

_____ _____

_____ _____

**Please initial all that apply:**
I wish to be contacted about my appointments and protected health information by:

_____Home Telephone_____

_____Answering Machine with detail (phone number)_____

_____Cell Phone_____

_____Text Message (phone number)_____

### I acknowledge that I have read the Notice of Privacy from Tina Snodgrass Skin Care Practice, PLLC.

**Consent:** I HEREBY CONSENT TO Tina Snodgrass Skin Care Practice, PLLC using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for health care services rendered to me or to carry out health care operations. I authorize examination and any other medical service deemed necessary by health care provider(s) or my insurance company, unless specifically requested in writing by me. This protected health information includes any personal or confidential information of a sensitive nature such as psychological, psychiatric records, substance abuse, drug or alcohol treatment or information pertaining to communicable diseases, (including HIV status, hepatitis's, venereal disease, etc.). I understand and agree to these conditions as a patient at Tina Snodgrass Skin Care Practice, PLLC.

By signing my name below, I certify that I have read the above information. Any questions concerning these policies have been discussed. My signature also certifies my understanding of and agreement with the policies. You may receive a copy of this document upon request.

Patient/Guardian Signature_____Date_____

Relationship to patient (if applicable) _____

This acknowledgement will be filed in the patient record.