

Acknowledgement of Receipt of Privacy Notice

By signing this for, you are agreeing that you have received a copy of Barry A. Nelms, M.D. Privacy Notice, which describes how we use and disclose your health information. You have the right to refuse to sign this Acknowledgement, in which case we must document our good faith effort to obtain your acknowledgement and the reason why it was not obtained.

Receipt of Privacy Notice of acknowledge by:

Signature

Date

Print Name

Relationship to patient:

* Self Other: _____

Consent to Examine and Treat

I acknowledge that I am legally and financially responsible in connection with the medical care and treatment provided and promise to pay whatever charges are not covered my health plan for services rendered to the patient listed below.

I understand this consent is valid as long as I receive medical care from Dr. Nelms.

Guarantor Signature _____ Date _____

Print Guarantor Name _____ Relationship to Patient _____

Print Name _____ Patient Date of Birth _____

* Patient, spouse, legal representative, or beneficiary (Patient's spouse may authorize disclosure of patient's health information only when the health information is for the sole purpose of processing an application for health insurance, for enrollment in a health care service plan or an employee benefit plan, and where patient is to be an enrolled spouse or dependent under the policy or plan).