Cobb Internal Medicine Associates, PC
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cobbinternalmedicine.com

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Acknowledgement of Receipt of "NOTICE OF PRIVACY PRACTICES"

You may complete this form online-Print & BRING TO YOUR APPOINTMENT to SIGN AT OUR OFFICE.

I, _____, D.O.B: ____/____ /_____acknowledge that I have received a copy of Cobb Internal Medicine Associates' "NOTICE OF PRIVACY PRACTICES" on the date set forth below. I grant permission to leave medical information in the specified manner and to the specified person(s) set forth below.

APPROVED PHONE NUMBERS FOR PERSONAL HEALTH COMMUNICATIONS (or opt out below)
You may leave PERSONAL MESSAGES INCLUDING LAB RESULTS on phone numbers below:

Mobile (_____) _____-_____ Home (_____) _____-_____ Work (_____) _____-_____

or opt out (enter "X")→____ No Personal Health Messages except appointment confirmations/changes

DESIGNATED PEOPLE WE MAY SHARE YOUR MEDICAL & ACCOUNT INFO WITH (or opt out below)
You may share medical and account information with this/these designated individual(s) as follows:
Name_____ Relationship to you? _____
D.O.B. _____ /_____ /_____ Phone (_____) _____-_____
Name_____ Relationship to you? _____
D.O.B. _____ /_____ /_____ Phone (_____) _____-_____

or opt out (enter "X")→____ Do not share information with anyone other than me.

If you provide your email address to Cobb Internal Medicine, your lab results will be available on our patient portal or on the HEALOW smartphone app.
You will receive an email notification when results are available online.

Email Address _____

After any lab testing, if you do not hear from the office within two weeks, please contact our office.

Patient/Guardian Signature _____ Date _____
Office or Other Witness Signature _____ Date _____

Assignment of Benefits/Consent for Treatment

I hereby voluntarily consent to treatment at this office and authorize such treatments, examinations, medications (including, but not limited to the use of the lab) as ordered by attending physicians. This assignment will remain in effect until revoked by me in writing. I understand that I am responsible for all charges not paid by insurance. I authorize this office to release all information necessary to secure payment.

Patient/Guardian Signature _____ Date _____
Office or Other Witness Signature _____ Date _____

Policies and Procedures

I have been provided the opportunity to read, or it has been read to me, the Policies and Procedures at Cobb Internal Medicine Associates. I have been provided with a copy of the Policies and Procedures at Cobb Internal Medicine Associates. I understand the Policies and Procedures of Cobb Internal Medicine Associates.

Patient/Guardian Signature _____ Date _____
Office or Other Witness Signature _____ Date _____