

## ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I have been informed about the Notice of Privacy Practices for Calvert Hearing Care and have been given the opportunity to read and review the document. It has been made available should I wish to take a copy with me. My signature below acknowledges my acceptance of these privacy practices of Calvert Hearing Care.

\_\_\_\_\_  
Patient Name \_\_\_\_\_ Date

\_\_\_\_\_  
Patient Signature (or legal guardian) \_\_\_\_\_ Date

\_\_\_\_\_  
Witness \_\_\_\_\_ Date

I give permission for Calvert Hearing Care to contact me at the following locations:

- |  |  |
|--|--|
| <input type="checkbox"/> Home Phone Number | <input type="checkbox"/> Email Address   |
| <input type="checkbox"/> Cell Phone Number | <input type="checkbox"/> Mailing to home address by<br>postcard, letter or tri-fold mailer |
| <input type="checkbox"/> Work Phone Number |  |

### 2009 Patient Information

Mr.( ) Mrs.( ) Ms.( ) Miss( ) Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Address \_\_\_\_\_

Email Address: \_\_\_\_\_

City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Employer \_\_\_\_\_

Work Phone \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Emergency Contact \_\_\_\_\_

Relationship \_\_\_\_\_

Emerg. Contact Phone \_\_\_\_\_

Primary Physician: \_\_\_\_\_