Slower Medicine
Direct Primary Care — it's about TIME.

Today's Date: _____

HIPAA Acknowledgement and Consent

The undersigned understands that the Medical Center is required by law to maintain privacy of protected health information and has provided the patient/patient's representative with a notice of its privacy practices regarding health information.

Patient's Name: _____ **Date of Birth:** _____

Patient Signature: _____

_____

Patients Representative (if applicable) **Relationship to Patient**

Slower Medicine Will Communicate Using:

- ☐ **Office will leave messages on voicemail.**
- ☐ **Office will call or text cell phone for reminders and other communication. Please verify the best number: _____.**
- ☐ **Office will send email correspondence in regards to various aspects of care.**
- ☐ **My health information my be discussed with the following individuals. Please list: _____**

_____

FINANCIAL AGREEMENT/GUARANTEE OF PAYMENT

I, _____, (print name) agree to promptly pay Slower Medicine for any outstanding Medical Services for all charges resulting from this office appointment as the statement is presented, in accordance with federal and state law, and provide permission to Slower Medicine or its designee to contact me via email, cell phone, and/or other communications methodology I provide for any activity related to treatment, payment, and/or other healthcare activities.

Patient Signature: _____ **Date:** _____