RECEIPT OF ACKNOWLEDGEMENT OF PRIVACY

I hereby acknowledge that I was offered to read or take with me a copy of the Privacy Policy issued by Empower Psychiatry & Sleep LLC, on the date indicated below. I understand that I may ask for a copy at any time.

To respect your privacy please tell us how we may contact you:

Home Phone:

- ❑ You may leave a message with the following person(s) if I am not available: _____
- ❑ You may leave DETAILED INFORMATION on my answering machine.
- ❑ You may leave your NAME and PHONE NUMBER ONLY on my voicemail and I will return your call.

Work Phone:

- ❑ You may call my work place.
- ❑ You may leave DETAILED INFORMATION on my work voicemail.
- ❑ You may leave your NAME and PHONE NUMBER ONLY on my work voicemail and I will return your call.
- ❑ You may NOT call my workplace.

Please list spouses, family, friends, caretaker, etc. that we may communicate with in regards to your personal medical and financial information. Also, please list Power of Attorney or next of kin. This will include but is not limited to: test results, appointment dates and times, and billing information. Only the names that are listed below will be able to receive your information. Do not include your physicians on this list.

1. _____ Phone: _____
2. _____ Phone: _____
3. _____ Phone: _____
4. _____ Phone: _____

Unless you notify us in writing stating otherwise the above person(s) will always be able to receive information about you.

_____ _____

Patient's Signature Date