

Informed Consent-HIPPA Notice of Privacy Practices Signature Page

Please review the **HIPPA Notice of Privacy Practices** and **Informed Consent for Treatment**, available upon request at our office or on our website, www.mycobm.com, under the Patient Forms tab.

Your signature indicates that you acknowledge and agree to the following statements:

- I have reviewed the HIPPA Notice of Privacy Practices and have been provided the opportunity to ask questions.
- I have reviewed the Informed Consent for Treatment and have been provided the opportunity to ask questions.
- My signature below acknowledges that I understand its contents and agree to abide by the terms in the agreement. If a minor is involved, then I am signing as the parent or legal guardian of the child.

Patient Name (Please Print): _____

Patient Signature/Date: _____

Parent/Guardian Signature (if minor)/Date: _____

Relation to Patient: _____

Provider Signature/Date: _____