Atlanta Cardiology Consultants, P.C.

Thomas S. Backer, M.D., F.A.C.C. / Katie Steffen, MMSC PA-C

Acknowledgement of Receipt of Privacy Practices

I, _____, have received or been given an opportunity to review a copy of Atlanta Cardiology Consultants, P.C. Notice of Privacy Practices.

_____ _____

Signature Date

Patient Agreement for Communications

I, _____, understand that as part of my health care Atlanta Cardiology Consultants, P.C. will need to contact me from time to time for the purposes of reminding me of an appointment, relaying the results of a test, advising me of a special precautions and measures that I need to follow prior to a procedure, to follow-up after a procedure, etc. I hereby authorize Atlanta Cardiology Consultants, P.C. to contact me in the following ways:

_____ Home Phone (voicemail) Number: _____

_____ Office Phone (voicemail) Number: _____

_____ Cell Phone (voicemail) Number: _____

_____ Fax Number: _____

I authorize Atlanta Cardiology Consultants, P.C. to speak with the following person/s and release information on my behalf:

_____

_____

I understand that Atlanta Cardiology Consults, P.C. will use the minimum necessary information needed when they communicate with me indirectly. I understand that I can revoke or amend this agreement at any time. Any revocation or change will not apply to communications already complete.

Patient Name: _____ Date of Birth: _____

Patient ID: _____ SSN: _____

_____ _____

Signature Date