NAVEEN MISHRA, D.O.

2267 Lava Ridge Court
Suite 125
Roseville, CA 95661

Phone: (916) 771-3717
Fax: (916) 771-3727
www.healthymindstoday.com

PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM

_____ (Patient initials) I give permission for telephone messages regarding protected health information to be left at the following numbers (check all that apply and WRITE DOWN the applicable number on the line provided
Home Phone (including voicemail/answering machine):
_____
Cell Phone (including voicemail):
_____
Other Phone (please specify what type of number. i.e. Work, mother, etc.):
_____

Consent to Text Usage for Appointment Reminders and Other Healthcare Communications:
Patients in our practice may be contacted text messaging to remind you of an appointment, and to provide general health reminders/information. If at any time I provide a text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at text address from the Practice.
_____ (Patient initials) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive text messages will apply to all future appointment reminders/health information unless I request a change in writing (see revocation section below). The cell phone number that I authorize to receive text messages for appointment reminders and general health reminders/information is_____.
The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details)

Notice of Privacy Practices.

I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Office if I have a question or complaint. I understand that this information may be disclosed e to the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

_____ _____
Signature Date

_____ _____
Name Date of Birth