

PALM BEACH FERTILITY CENTER  
7015 Beracasa Way Suite 201  
Boca Raton, FL 33433  
Ph: 561-477-7728 Fax: 561-477-7035

I hereby acknowledge that I have received a copy of this medical practice's Notice of Privacy Practices.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Ph#: \_\_\_\_\_

**Patient Contact**

All calls regarding your care, test results and appointments will be made to your home phone number. If you would like us to contact you at an alternate phone number, please indicate that number here

\_\_\_\_\_.

\_\_\_\_\_ I hereby authorize this medical practice to contact me by telephone and if I am not present, leave a message on my answering machine.

\_\_\_\_\_ I prefer that you do **NOT** leave a message on my answering machine.

**Other Contact Information**

The following people, other than a duly designated guardian or conservator, are authorized to discuss my \_\_\_\_\_ medical condition and/or \_\_\_\_\_ billing information with a healthcare professional in this practice:

_____	_____	_____
Name	Relationship	Ph#

_____	_____	_____
Name	Relationship	Ph#

_____	_____	_____
Name	Relationship	Ph#

**For Office Use Only:**

Signed form received by: (Please Print) \_\_\_\_\_ Initials: \_\_\_\_\_

Acknowledgement Refused: \_\_\_\_\_

Efforts to Obtain: \_\_\_\_\_

Reasons for Refusal: \_\_\_\_\_