PRIVACY PRACTICES

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices for the offices of Dr. Jack M. Thomas. I have been provided an opportunity to review it.

□ I authorize you to release information to the following individuals regarding my medical treatment. You may release this information either by phone or by mail.

_____

Name Relationship

_____

Name Relationship

□ I AUTHORIZE you to leave information regarding appointments via answering machine or e-mail.

□ I DO NOT AUTHORIZE you to leave information regarding appointments via answering machine or e-mail.

Name: _____ Birthdate: _____

Signature: _____

Date: _____

FINANCIAL POLICY

ACKNOWLEDGEMENT FORM

I have received the Financial Policy for Dr. Jack M. Thomas, and I have been provided an opportunity to review it.

Name: _____ Birthdate: _____

Signature: _____

Date: _____