Carolina Hand and Sports Medicine, P.A. (CHASM) has a legal responsibility to protect the privacy of your personal health information (PHI). In addition, we are required by law to provide you with our notice.
I give CHASM my consent and authorization to discuss my personal health information to the people and/or facilities I have listed below. This consent and authorization will also include who I have listed as my emergency contact as well.

_____

Name Relationship Contact number

_____

Name Relationship Contact number

_____

Name Relationship Contact number

_____

PRIMARY CARE PHYSICIAN Contact number

In case of an emergency, please notify:

_____

_____

Name Relationship Contact number

I am also consenting to the following: CHASM may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. CHASM may mail to my home or other alternative location(s) any items that assist the practice in carrying out treatment or payment operations. CHASM may also call my home or other alternative location(s) and leave a message on voice mail regarding appointment reminders, insurance related questions, unpaid balance(s) or medical information. At my request, CHASM may also send my personal health information pertaining to treatment, payment or administrative operations using email communication. I understand that this communication method (email) is unencrypted and aware of the potential liabilities. **I have received a copy and/or reviewed Carolina Hand and Sports Medicine, P.A. (CHASM) Notice of Privacy Practices. _____ PLEASE INITIAL**

For Appointment Reminders, I preferred to be contacted by:

□ **Text messaging #**_____ □ **Phone call #**_____

□ **Email:** _____

Late Arrival Policy: When a patient arrives late, the time spent with the patient is minimized and does not allow for a full assessment. It also disrupts the schedules of our providers and other patients.
Also, each clinic is different based on provider, patient flow and sometimes unplanned emergencies.

Therefore, it is our policy that your appointment may be rescheduled should you arrive late for your scheduled appointment. _____PLEASE INITIAL

Printed name of Patient:_____

Signature of Patient/Parent/Legal Guardian:_____ Date: _____