Evolve Medical Spa
101 East Market St
Suite 3C
Smithfield, NC 27577
(919) 205-1376

REQUEST FOR THE PROVISION OF MEDICAL SERVICES AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF HEALTH INFORMATION PRIVACY PRACTICE (HIPPA)

Before you give your consent, be sure you understand the information given below. If you have any questions, we will be happy to talk about them with you. You may ask for a copy of this form. I understand that I should ask questions about anything I do not understand. I understand that a provider is available to answer any questions I may have. No guarantee has been given to me as to the results that may be obtained from any services I receive. I know that it is my choice whether or not to have services. I know that at any time, I can change my mind about receiving medical services at Evolve Medical Spa.

I understand that confidentiality will be maintained as much as is possible. I understand upon my request my right to review and make changes to my medical record that I find inconsistent with my medical history. I hereby request that a person authorized by Evolve Medical Spa provide appropriate evaluation, testing and treatment.

I hereby acknowledge receipt of Evolve Medical Spa notice of health information private practices.

Signature of Patient_____Date_____

I witness the fact that the patient received the above mentioned information and said he/she read and understood the same.

Signature of Witness_____Date_____

CHECK HERE IF PATIENT'S GUARDIAN OR RELATIVE IS LEGALLY REQUIRED TO SIGN BELOW

Signature of any other person consenting_____
Relationship to patient_____Date_____

I witness the fact that the patient's legal guardian (or person consenting on their behalf) received the above mentioned information, and said he/she read and understood same.

Signature of Witness_____Date_____