

**Theresa Lerch, CNM CFNP-BC**

**Lori Bowdler, FNP-BC**

**Caitlin Shea FNP-C**

## **NOTICE OF PRIVACY PRACTICES**

### **Acknowledgement of Receipt**

By signing this form, you acknowledge receipt of the Notice of Privacy and Communication Practices for Theresa Lerch. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information (PHI). We encourage you to read it in full.

### **COMMUNICATION PRACTICES**

Theresa Lerch CFNP CNM, Lori Bowdler FNP-BC and/or Caitlin Shea FNP-C may engage in one of more of the following activities:

- A. May contact me to provide appointment reminders or information about treatment alternatives or other health-related benefits and services.

\_\_\_\_\_ I give permission to leave appointment information on my answering machine or voicemail.

\_\_\_\_\_ I give permission to contact me at work with appointment or treatment information.

- B. May disclose protected health information to your insurance provider.

\_\_\_\_\_ I understand Theresa Lerch CFNP CNM, Lori Bowdler FNP-BC and/or Caitlin Shea FNP-C has permission to send medical records to my insurance provider if required to process a claim. I also understand if I refuse, I will be financially responsible for the amount insurance denies due to lack of medical records.

I, \_\_\_\_\_, have received a copy of the Notice of Privacy Practices.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date of Birth

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