Vascular Institute *for* Erectile Dysfunction

PATIENT NAME:_____ DOB:_____TODAY'S DATE: _____

## Notice of Privacy Practices

Our Notice of Privacy Practices outlines the meticulous care with which we manage and disclose your protected health information. It's your right to review our Notice before affirming your acknowledgment through signing.

By proceeding with your signature, you confirm that you've been apprised of how we utilize and disclose your health information, as delineated in our Notice. Furthermore, a copy of our Notice is accessible to you both here and on our website, https://vascular4ed.com/ , under the Resources Tab. Your understanding of the Notice, its contents and its application to your information is essential, and we are here to ensure all your queries regarding our Notice are comprehensively addressed to your satisfaction.

**Patient Signature: _____Date: _____**

## Contact Methods for Appointment Booking, Follow-up & Evaluation of Services

I acknowledge and agree that Vascular Institute for Erectile Dysfunction may contact me by telephone or by text message to the telephone numbers I provided. I further agree that Vascular Institute for Erectile Dysfunction may use any method of contact to any of these telephone numbers, including prerecorded or artificial voice messages, text messages and automatic dialing devices.

I acknowledge and agree that Vascular Institute for Erectile Dysfunction may contact me via electronic mail using any email address I provided. I take sole responsibility for maintaining the privacy of any of the information sent to me.

I further understand that in order to revoke my consent to be contacted, I must send a written revocation of my consent to Vascular Institute for Erectile Dysfunction at 2174 NW Plumbago Trail, Stuart FL 34994.

I give permission for Vascular Institute for Erectile Dysfunction to contact me for the purpose of evaluating the services rendered to me.

By proceeding with your signature, you confirm that you have read, understood, and agree to the terms for Contact Methods for Appointment Booking, Follow-up & Evaluation of Services, stated above.

**Patient Signature: _____Date: _____**