

HIPAA Acknowledgement and Consent

The undersigned understands that the Medical Center is required by law to maintain privacy of protected health information and has provided the patient/patient's representative with a notice of its privacy practices regarding health information.

Patient's Name: _____ Date of Birth: _____

Patient Signature: _____

Patients Representative (if applicable)

Relationship to Patient

Please check all that may apply:

- Office may leave message on answering machine.
- Office may call cell phone _____.
- Office may call patient at work _____.
- Office may leave message with spouse and/or significant other.
- Office should only speak with patient.
- Information may be given to other family members. List: _____

FINANCIAL AGREEMENT/GUARANTEE OF PAYMENT

I, _____, (print name) agree to promptly pay Arnot Health for all charges resulting from this office appointment as the statement is presented, in accordance with federal and state law, and provide permission to Arnot Health or its designee to contact me via email, cell phone, and/or other communications methodology I provide for any activity related to treatment, payment. And/or other healthcare activities.

Patient Signature: _____ Date: _____

Office Use Only:

An attempt was made to obtain a written acknowledgement of receipt of our Notice Privacy Practices, but the acknowledgment could not be obtained because:

- The individual refused to sign
- An emergency situation prevented our obtaining the acknowledgement
- Other (please specify) _____

Employee: _____ Date: _____