ArnotHealth

Arnot Medical Services

HIPAA Acknowledgement and Consent

Today's Date: ______________________

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: ____

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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 Ogden Medical Center and Arnot Medical Services 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:** _________________

AMS 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) ___________________________________

AMS Employee: ____________________________________ Date: ______________________