



Family Health Care
Baldwin • Cadillac • Grant • McBain • White Cloud
 www.familyhealthcare.org



BALDWIN FAMILY HEALTH CARE/GREAT LAKES FAMILY CARE
NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT & SIGNATURE FORM

Patients Name (Please Print): _____ **Birthdate:** _____

The Notice of Privacy Practices describes how the Facility uses and discloses your health information and the circumstances under which we must seek your written permission to do so. The Notice of Privacy Practices also describes rights you have under federal regulations called the Health Insurance Portability and Accountability Act ("HIPAA"). HIPAA requires us to provide you with the Facility's Notice of Privacy Practices, and to obtain your written acknowledgment for receiving it.

By signing this form, you are acknowledging that the Facility provided you with its Notice of Privacy Practices; by signing, you are not agreeing or disagreeing with its content. If you do disagree, the Notice of Privacy Practices provides information about how you may address your concerns. By signing below, I acknowledge receiving the Facility's Notice of Privacy Practices.

(X) _____
 Signature of Patient or Representative _____ Date _____

Representative's Relationship to Patient (if applicable)

For Office Use Only

If an acknowledgment is not obtained, document below provider's good faith efforts to obtain the acknowledgment and the reason why the acknowledgment was not obtained:

Individual's name: _____
 Date of attempt to obtain Acknowledgment: _____
 Reason Acknowledgment was not obtained: _____

_____ I hereby acknowledge that I have received a copy of BFHC/GLFC'S Mission Statement and Patient Rights and **Initial** Responsibilities.

I hereby authorize BFHC/GLFC and the Provider assigned, as provided by law, to furnish medical/dental, office surgery or diagnostic treatment and any local anesthetic as he/she considers necessary and proper in the treatment of the patient for the purpose of correcting his/her physical condition.

_____ This authorization shall be valid until rescinded in writing or replaced by one of a later date

Initial

I request that payment of authorized Medicare and/or insurance benefits be made on my behalf to Baldwin Family Health Care for any services rendered to me by them. I authorize any holder of medical/dental information about me to release to the Centers for Medicaid and Medicare Services (CMS) and/or the Insurance Carrier and their Agents any information needed to determine these benefits of the benefits payable for related services. I acknowledge full responsibility for the payment of services and agree to pay for them at the time service is rendered, unless other arrangements are made.

_____ Note: Your blood may be tested for HIV or Hepatitis if an employee is exposed to your body fluids. This is in compliance **Initial** with Public Act #448.

BALDWIN FAMILY HEALTH CARE/GREAT LAKES FAMILY CARE DISCLOSURE REQUEST

May we disclose health information about you to family members and friends who are involved in your care or the payment thereof?

- Yes, you can discuss my care with any of my family members for friends that inquire about me.
- No, you can only disclose information to me.
- Yes, but only to the following individual(s):

_____	_____ \
Name	Relationship to patient
_____	_____
Name	Relationship to patient

(X) _____
 Signature _____ Relationship, if not patient _____

_____ Date _____
 Witness