



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's Mission Statement and Patient Rights and

Initial Responsibilities.

I hereby authorize BFHC and the Provider assigned, as provided by law, to furnish medical/dental/optical, 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This authorization shall be valid until rescinded in writing or replaced by one of a later date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/optical 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 with Public Act #448.

Initial

\*\*\*\*\*

BALDWIN FAMILY HEALTH 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 or 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

Witness

Date