Hopewell Health Centers, Inc.
Patient Acknowledgement Form for
Receipt of Health Information Privacy Practices

I, _____ _____, understand that as part of my (or my child's)
(Patient) (D.O.B.)
health care, this office keeps health records describing my health history, a list of symptoms or medical problems, details on the doctor's examination of me, results from tests that I've had, my diagnosis, treatment, and any future plans for treatment. I understand that this record serves as:

- A way for my health care provider to plan my care and treatment
- A way for all the health professionals involved in my care to have the same information
- Information that can be given to my insurance company or the agency paying for my care so they can make sure I received the services that Hopewell Health Centers billed for,
- And as a way for Hopewell Health Centers to make sure they are providing me with the best care possible.

Hopewell Health Centers also has a No Show policy which is:

- All patients must call 24 hrs in advance to cancel appointment
- Do not leave a message with the answering service, you must speak with the office staff
- Medical and Behavioral Health new patients who no show cannot reschedule for 3 months
- Dental new patients who no show cannot reschedule for 6 months
- 3 no shows in a 12 month period can result in dismissal from the practice

I have also been given a copy of the *Notice of Information Privacy Practices* and *Patient Code of Conduct* that tells more about the items listed above. I understand that if I have any questions either now or in the future about this information, I can talk to a staff member.

If I am attending a Behavioral Health appointment I have been given the *Consumer Handbook* which also contains client's rights information.

When filling out this document on-screen, you must complete this Acceptance section. NOTE: By selecting "I Accept," you are confirming your intent to sign this document electronically.

ACCEPTANCE OF ELECTRONIC SIGNATURE:

☐ I ACCEPT. I am signing this document by typing my name in the Signature field below.

☐ I DO NOT ACCEPT. I will print out and sign a paper copy and deliver or mail it to my healthcare provider.

Patient/Guarantor Signature _____ Date: _____

Clear Form

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