NEA BAPTIST CLINIC

HIPAA PRIVACY NOTICE ACKNOWLEDGMENT

Patient Name: _____
First Middle Initial Last

DOB:_____ MRN:_____ SSN:_____

The signature below acknowledges a copy of this Notice was RECEIVED (not necessarily read).

_____ _____
Date Patient/Legal Representative Signature

_____
State Capacity, if Legal Representative

For internal use only

Lack of Patient Acknowledgment:

Date	**Reason**	**Staff Signature**

AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION

With whom may we share information about your health? Please list below.

Note: In order for NEA to disclose your Private Health Information, the representative listed must be able to provide (2) two of the (3) identifiers listed below:

1. Last 4 digits patient's social security number **2. Patient's date of birth** **3. Patient's zip code**

Name	Relationship to You	Telephone Number	May Discuss Diagnosis/Treatment	May Discuss Billing Info
_____	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No

Do you have a legal document that states who will make decisions if you are unable? ☐ Yes ☐ No

If yes, Name_____ Relationship to Patient_____

Check one: ☐ Healthcare Proxy/Agent ☐ General Power of Attorney ☐ Healthcare Power of Attorney

If you would like information about appointing a healthcare proxy/agent, please let us know.

I understand that it is my responsibility to update this list in order to keep accurate those authorized persons to discuss and use the patient's healthcare information.

Patient/Legal Representative Signature:_____ Date: _____

If legal representative, explain the capacity: _____

OFFICE USE ONLY - SCAN DOCUMENT UNDER HIPAA NOTICE OF PRIVACY

NEA BAPTIST CLINIC

Authorizations & Consents

Date_____ DOB_____ MRN_____

Patient Name_____
First Middle Initial Last

Communications Regarding My Account

Initial Here _____ I agree that the facility, NEA Baptist Clinic, or any other collection or servicing agency or agencies retained by the facility or my physicians (together referred to hereafter as "collectors") to collect any money that I owe to the facility, may contact me by telephone or text message at any number given by me or that is or becomes associated with me or my account from sources other than me, including but not limited to, cellular/wireless telephone numbers which may result in my incurring fees for the call or text message. I understand, acknowledge and agree that the collectors may contact me by automatic dialing devices and through pre-recorded messages, artificial voice messages or voice mail messages. I further agree that the collectors may contact me using e-mail at any e-mail address I provide to the facility or is otherwise associated with my account.

General Consent to Treatment and Test

Initial Here _____ I am voluntarily seeking medical treatment. I consent to examination by the physician, nurse practitioner, nurse and other health care professionals at this clinic. I also consent to any medical procedures, x-ray, laboratory tests or other health care services ordered by the health care team. I understand that I may refuse specific treatments or procedures by informing the health care team. I understand that a clinical summary of today's visit is available upon request within 72 hours.

Release of Information

Initial Here _____ I authorize NEA Baptist Clinic to release any medical information necessary to process payment of my claim.

Assignment of Insurance Benefits and Acceptance of Financial Responsibility

Initial Here _____ I authorize payment directly to NEA Baptist Clinic for their fees. I understand and agree that if any part of my account is not paid by insurance, I am financially responsible. I also understand that I may qualify for financial assistance for services provided by NEA Baptist Clinic and that I may request an application to apply for financial assistance. I further understand that the determination of whether I qualify for financial assistance is dependent upon my timely submittal of appropriate financial documentation and my failure to provide any such documentation could affect my ability to qualify for financial assistance.

_____ Date_____
SIGNATURE OF PATIENT/PARENT/GUARDIAN/PERSON AUTHORIZED TO SIGN FOR PATIENT

OFFICE USE ONLY - SCAN DOCUMENT UNDER AMB_AUTH AND CONSENTS