TMH Medical Clinic
(970)826-2400 office (970)826-2439 fax
785 Russell Street, Craig, CO 81625

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I received TMH Medical Clinic's Notice of Privacy Practices.

_____ _____
Patient Name (Please Print) Date of Birth

_____ _____
Signature Date

Documentation of Good Faith Efforts
To obtain patient's acknowledgment that they received the provider's Notice of Privacy Practices.

(For use when acknowledgment cannot be obtained from the patient)

The patient presented to the office on _____ and was provided with a copy of Covered Entity's Notice of Privacy Practices. A good faith effort was made to obtain from the patient written acknowledgment of his/her receipt of the Notice. However, such acknowledgment was not obtained because:

____ Patient refused to sign.

____ Patient was unable to sign or initial because:_____

____ The patient had a medical emergency, and an attempt to obtain the acknowledgment will be made at the next available opportunity.

____ Other reason :_____

_____ _____
Signature of Employee Completing Form Date

AUTHORIZATION FOR TREATMENT: I authorize treatment for the care of the above mentioned patient including immunizations.
FINANCIAL POLICY: I authorize the release of any medical information to my insurance carrier. I authorize all insurance payments be made directly to The Memorial Hospital. I understand that I am responsible for all charges incurred by my dependants or myself. Payment is due at the time of service, unless prior arrangements have been made. I agree to pay all reasonable attorney fees and collection costs in the event of payment default to my accounts.
I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS AND AGREE TO ALL THE TERMS STATED THEREIN.

Signature: _____ Date: _____