COMMUNITY HEALTH & WELLNESS PARTNERS

Care... To Live Life Fully

HIPAA

_____ _____

Patient Name: (Please Print) *Date of Birth*

_____ *Initials*

Acknowledgement of receipt of Notice of Privacy Practice regarding protected health information

I have received the Practice's Notice of Privacy. Photocopies of this document are to be as valid as the original. **Fundraising & Marketing**: Unless you request us not to, we will use your name and address to support our fundraising or marketing efforts. If you do not want to participate in fundraising or marketing efforts, please check off the following box.

Please exclude me from any ☐ **Fundraising Purposes** ☐ **Marketing Purposes**

_____ *Initials*

Assignment of Benefits:

I acknowledge financial responsibility for all facility and physician fees. I understand that the physician billing office will file my insurance claim and I assign direct payment to the physician for all payments made under the terms and provisions of my policy. I further understand that any disputes on coverage are between my insurance carrier and myself and I will be responsible for payment for denied services regardless of the outcome of my dispute. I acknowledge financial responsibility for all charges if inaccurate insurance information is given at the time of service and the information is not corrected prior to my insurance company's timely filing limit.

_____ *Initials*

Medical Records Exchange:

CHWP participates in one or more Health Information Exchanges (HIE). HIEs are electronic networks that securely provide and retrieve access to your health records for a better picture of your health needs. CHWP Providers and other healthcare providers may provide and retrieve access to your health information through an HIE for treatment, payment, or other healthcare operations. As a CHWP patient, you have the ability to opt out of any HIE at any time by notifying a CHWP Associate. This is a voluntary agreement. Unless you advise us differently, your information may be accessed through an HIE by your CHWP provider.

_____ *Initials*

Rx-History Consent:

I understand that performing a medication reconciliation in order to prevent adverse drug interactions and overdose is a critical component to my care. By initialing this section, I authorize my provider to query and review my medication fill history including drug, dose, form, strength, prescribing provider, and pharmacy.

_____ *Initials*

Communication Preferences Regarding PHI

To assist in your care, it may be necessary to release our Protected Health Information to someone other than yourself.

To whom may we talk? Please check the boxes and write in the name(s).

Yes	No	
☐	☐	Spouse/Significant other: _____
☐	☐	Parent/Step-Parent: _____
☐	☐	Child/Grandchild: _____
☐	☐	Other Person(s): _____
☐	☐	Emergency Contact: _____

_____ *Initials*

Communication by e-mail or Text

I hereby authorize Community Health and Wellness Partners ("Provider") and other medical professionals or staff members that the Provider has designated to communicate with me, and the Caregivers identified above, if any, about my medical conditions and treatment using unencrypted text messages, if I have provided a mobile phone number, and/or unencrypted e-mail, if I have provided an e-mail address, including those that may be considered marketing messages (e.g. flu shot reminders, etc.). I acknowledge that text messages are inherently unsecure and may be able to be accessed by third parties.

_____ *Initials*

May we leave a message on: ☐Home ☐Cell ☐ Work

Preferred method for appointment reminder (Check all that apply**):**

☐ Call to Home ☐ Call to Mobile ☐ Text to Mobile

Preferred time for reminder calls: ☐ Morning ☐ Afternoon ☐ Evening

_____ _____

Patient/Representative Signature Date