815-759-2368

General Acknowledgments

Patient Acknowledgement of Independent Physicians

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Initials

I acknowledge the independent professional(s) who is providing services at PVC are employees of PVC. I understand that a need may arise where a specialist may be called to assist and I will receive a bill from these independent professionals. I have read and understand the above terms and confirm I am the patient or am authorized to sign on the patient's behalf.

Use and Disclosure if Health Information

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Initials

I understand PVC will use and disclose my health information for the purpose of treatment, payment, and health care operations, as permitted by law. Certain information can be used without obtaining my consent. I fully understand that the use of disclosure of my health information may include history, diagnosis and/or diagnostic treatment of mental health / developmental disabilities conditions, alcohol or drug abuse and Acquired Immune Deficiency Syndrome (AIDS/HIV).

I understand if I refuse to allow disclosure of my health information to process my insurance claim, I may be financially responsible for all costs incurred by me for treatment. I agree to release and hold harmless PVC, its agents and employees from any liability that may arise from the use or disclosure of my health information.

Pictures/Images

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Initials

I understand photographs, videotapes or other images may be taken to document my care. These images may be kept by PVC and/or NM and/or the independent physicians involved in my care. I understand I have the right to view or obtain copies of these materials which are in possession of PVC and/or NM upon written request. It is my responsibility to confirm if such photographs, videotapes or other images have been taken. I understand images identifying me will only be released as allowable under the law or with written authorization.

Release from Liability for Valuables

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Initials

I understand my belongings are my responsibility and I have been advised to send any items of value home. I release PVC from any liability for the loss, damage to or theft of any of my belongings.

Receipt of Physician's Notice of Privacy (HIPPA)

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Initials

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

Patient Certification

By signing this General Acknowledgment Form, I acknowledge I have read and understand the information contained in this form and accept its terms. I also acknowledge I may receive a copy of this form for my records.

_____ _____
Patient/Authorized Person Date

_____
Witness