INDIVIDUAL DOCUMENT ACKNOWLEDGEMENT REGISTRATION FORM

I acknowledge that I received a copy of the Beacon Health Alliance, P.C. Notice of Privacy Practice dated September 23, 2013, for myself or minor child: _____ PATIENT'S DOB: _____

[Please **PRINT** Full Legal Name of Patient]

Patient signature if over 18 years of age: _____

Signature of parent/legal guardian if minor child: _____

Personal representative, if parent/legal guardian is not present: _____

_____ _____

Witness Signature **Date**

I hereby authorize the following for myself if over 18 years of age or minor child (**INITIAL all that apply**)

_____Release of medical information to other medical providers, by phone, in person, or by mail as necessary for continued care process.

_____Release of medical information to other medical providers, as necessary, via fax, as requested by them.

_____Release of medical information as necessary, via fax, interoffice courier, phone, in person, or by mail for claims/billing processes.

_____Voicemail messages on my personal phone/answering machine regarding appointments/callbacks, etc.

_____I acknowledge that I have received for review the Patient's Privacy of Healthcare Information in accordance with HIPAA federal regulations.

_____I authorize the following person(s) to be given Private Health Information regarding myself/child while in the office for treatment or to receive PHI, i.e. test results, call backs, appointments, etc. via telephone in my absence:

_____Relationship to patient: _____Phone #: _____

_____Relationship to patient: _____Phone #: _____

_____Relationship to patient: _____Phone #: _____

COMMUNICATIONS CONSENT: By providing my cell, landline, or any other number(s), I expressly consent to receiving communications from the Provider, its staff, its contractors, collection agents, and other, at any numbers I provide or that are later acquired for me. These parties may use this information to contact me by live agent, voice mail, text message, using an auto dialer or other computer assisted technology, prerecorded message(s), or by any other form of electronic communication for any purpose including, but not limited to, appointment and follow-up health care reminders, scheduling, my account(s), assignment of benefits, and/or financial responsibility. I understand that depending on my phone plan I could be charged for these calls or text messages. I agree to provide new number(s) if my number(s) change. Providing these numbers is not a condition of receiving healthcare services. ☐ **Accept** ☐ **Decline**

_____ _____

Signature of Patient, Legal Representative or Legal Guardian **Date**

Patient (if over 18 years of age) or parent/personal representative did not sign the acknowledgment for the following reason: (Check ☑ one of the reasons below)

☐ Individual refused

☐ Individual refused, stating that he/she has already signed an acknowledgement for self or child.

☐ Individual unable to sign because of medical condition.

☐ There was not a personal representative of the individual available to sign (patient is underage).

☐ Other: (explain)_____

_____ _____

Witness Signature **Date**