**Grace Primary Care PLLC**

**6520 W. HWY. 22, Crestwood, KY 40014**

**Phone: (502)-241-8488 | Fax: (502)-241-7424**

# **PATIENT CONSENT FORM**

Dr. Renu George Vishnukant Joshi, DO Yoandis Martin, APRN, FNP-BC

I understand that, under the Health Insurance Probability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

* Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
* Obtain payment from third-party payers.
* Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by Grace Primary Care of the Notice of Privacy Practices containing a more complete description of the users and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that my private information be restricted to being used or disclosed to carry out treatment, payment or health care operations. I also understand Grace Primary Care is not required to agree to my requested restriction, however, if agreed to the requested restrictions, Grace Primary Care is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that action has been taken relating to this consent.

Patient Name:

Relationship to patient:

Signature:

Date:

**GRACE PRIMARY CARE**

Notification of No Show, Late Arrival and Late Cancellation Policy

Effective September 1, 2023

 Quality care for our patients is our priority. Please take a few minutes to review our no-show policy and sign at the bottom of the form. If you have any questions, please let us know.

 **This notice addresses the following:**

1. When patients do not show for their appointments **(“no show”)**

 2. When patients arrive past their appointment time **(“late arrival”)**

3. When patients cancel their appointments with less than 24 hrs notice **(“late cancellation”)**

When these occur, there is a significant negative impact on our practice and on our ability to provide quality timely care to our patients. These occurrences can negatively impact that patient’s healthcare, take away time that could be spent with other patients, and increase wait times for the practice.

**How to avoid No Shows, Late Arrivals and Late Cancellations:**

1. Confirm your appointment – The office will call the day before to confirm.

 2. Arrive at your confirmed arrival time (this is often a few minutes prior to your appointment time to give our staff time to update your records and complete your arrival)

 3. Give 24-hour notice for any appointment cancellations.

 **Consequences to No Shows, Late Arrivals and Late Cancellations**

1. You will receive a phone call, and/or a letter, letting you know we missed you at your appointment time.

2. You will be offered a re-scheduled appointment, but your wait time may be longer.

3. If you miss three or more of your appointments, you may be charged a $25 fee or dismissed from our practice.

I have read and understand the Grace Primary Care No Show, Late Arrival and Late Cancellation notice.

Signature of Patient or Patient’s Authorized Representative Date

Patient Name (Printed): Date of Birth:

Please answer ALL questions (Por favor responda TODAS las preguntas)

NAME(NOMBRE)

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ADDRESS (DIRECCIÓN)

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SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE(TELÉFONO)

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CELL/OTHER(CELULAR/OTRO)

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EMAIL(CORREO ELECTRÓNICO)

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INSURANCE/ID#(SEGURO/N.° DE IDENTIFICACIÓN)

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SPOUSE OR NEXT OF KIN(CÓNYUGE O PARIENTE MÁS PRÓXIMO)

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 IS IT OK TO DISCLOSE CONDITIONS, MEDICATIONS, AND OTHER INFORMATION WITH THIS PERSON?

 YES NO

(¿ESTÁ BIEN DIVULGAR CONDICIONES, MEDICAMENTOS Y OTRA INFORMACIÓN CON ESTE) ¿PERSONA? SÍ NO

ALLERGIES (ALERGIAS)

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PHARMACY(FARMACIA )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP CODE(CÓDIGO POSTAL

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EMPLOYER(EMPLEADOR

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SIGNATURE /DATE (\_FECHA DE FIRMA)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_