

PATIENT SIGNATURE CONFIRMATION

I hereby confirm that I have received copies of the following Kentucky Mountain Health Alliance, Inc. policies and documents and I have had the opportunity to ask questions about each of them. I acknowledge that these documents may be available upon request and maybe accessed through the Kentucky Mountain Health Alliance website www.kymha.com

- Sliding Fee Scale Policy
- Financial Policy
- Patient Rights/Grievances Policy
- HIV/AIDS Information
- Notice of Privacy Practices
- List of Services available

Signature of Patient or Legal Guardian: _____ **Date:** _____

Staff Signature: _____ **Date:** _____

If the patient is unable to sign, secure consent of Next of Kin or Legal Agent and indicate reasons by checking the appropriate box:

- ☐ Minor
- ☐ Disorientated
- ☐ Medically Unstable
- ☐ Incompetent

MRN# _____