

NOTICE OF PRIVACY PRACTICES (NPP) ACKNOWLEDGEMENT

A Notice of Privacy Practices (NPP) is provided to all patients and explains: (1) how your Protected Health Information (PHI) may be used or shared; (2) your rights to access or amend your PHI, request information on disclosures of your PHI, and request additional restrictions on our uses and disclosures of PHI; (3) your rights to complain if you believe your privacy rights have been violated; and (4) our responsibilities for maintaining the privacy of your PHI.

- I acknowledge that I have read the foregoing and received a copy of the “Notice of Privacy Practices” (Version 3 August 2013 dated 09/23/2013) that explains when, where, and why my Protected Health Information (PHI) may be used or shared.
- I authorize BHS Physician Network to furnish complete information, including Protected Health Information, requested by my insurance carrier or its intermediaries regarding services rendered. I hereby authorize my insurance carrier to furnish to BHS Physician Network any information obtained in the adjudication of any claim for services furnished to me by BHS Physician Network.
- I acknowledge that BHS Physician Network, the physicians, the nurses, and other staff may obtain and share any or all of my Protected Health Information, including prescription history, with other health care professionals in order to treat me, coordinate my care, and/or in order to arrange for payment of my bill and respond to any issues related to my care.
- I acknowledge that I have the right to request additional restrictions on the use and disclosure of my PHI if I so choose.

Printed Name of Patient: _____ Date of Birth: _____

Signature of Patient/Guardian: _____ Date: _____

Printed Name of Guardian: _____ Relationship to Patient: _____

FOR INTERNAL USE ONLY

Name of Employee

Signature of Employee

If applicable, reason patient’s written acknowledgment could not be obtained:

- Patient was unable to sign.
- Patient refused to sign.
- Other: _____

PATIENT COMMUNICATION CONSENT

We may need to contact you regarding your medical care, appointments, test results, referrals, or any other reason. This is to acknowledge that you authorize BHS Physician Network to contact you and how you wish to be contacted (check all that apply):

	ORDER OF PREFERENCE:	OK TO LEAVE VOICEMAIL?	PHONE NUMBER:
HOME PHONE	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	<input type="checkbox"/> YES <input type="checkbox"/> NO	
CELL PHONE	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	<input type="checkbox"/> YES <input type="checkbox"/> NO	
WORK PHONE	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	<input type="checkbox"/> YES <input type="checkbox"/> NO	
ALTERNATE PHONE	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	<input type="checkbox"/> YES <input type="checkbox"/> NO	
PATIENT PORTAL & SECURE EMAIL	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	EMAIL ADDRESS:	
<input type="checkbox"/> None of the above			

PHI DISCLOSURE TO FAMILY MEMBERS

You may authorize us to contact a family member regarding your medical care or financial matters. This is to acknowledge that you authorize BHS Physician Network to disclose your PHI to the following individuals (check all that apply):

Name: _____ **Relationship to Patient:** _____

Telephone: (_____) _____ **Email:** _____

Types of Information: Appointment Reminders Results (lab test, X-Ray, etc) Financial Other: _____

Okay to contact via: Telephone Leave a Voice Mail Patient Portal & Secure Email Other: _____

Name: _____ **Relationship to Patient:** _____

Telephone: (_____) _____ **Email:** _____

Types of Information: Appointment Reminders Results (lab test, X-Ray, etc) Financial Other: _____

Okay to contact via: Telephone Leave a Voice Mail Patient Portal & Secure Email Other: _____

Name: _____ **Relationship to Patient:** _____

Telephone: (_____) _____ **Email:** _____

Types of Information: Appointment Reminders Results (lab test, X-Ray, etc) Financial Other: _____

Okay to contact via: Telephone Leave a Voice Mail Patient Portal & Secure Email Other: _____

None of the above

Signature: _____