proactive md

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT TO TREAT

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement if you wish.

☐ I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

AUTHORIZATION TO GIVE MEDICAL CARE – CONSENT TO TREATMENT:

☐ I hereby voluntarily consent to outpatient care from the Proactive MD Health Center encompassing routine diagnostic procedures, examination, and medical treatment including (but not limited to) routine laboratory work and administration of medications as prescribed by the Providers. I further consent to the performance of those diagnostic procedures, examinations, and rendering of medical treatment by the Proactive MD Health Center's medical Providers and staff, as is deemed necessary in the judgment of the medical staff. I understand that during the course of treatment, health care workers may be exposed to the patients' blood and/or body fluids increasing their risk of contracting Hepatitis B, Hepatitis C, and/or HIV. In the event an exposure occurs, I understand the need for testing for these diseases and I agree to such testing of myself to promote the health and welfare of the health care worker. I understand that this consent will be valid and remain in effect as long as I attend the health center.

_____ _____

Print patient's name here *Print parent or guardian's name here if under 18*

_____ _____

Patient Signature *Parent or guardian's Signature*

_____ _____

Date *Minor's Date of Birth*

We cannot discuss your protected health information (PHI) with anyone other than yourself unless you authorize us to do so. Please list below names(s) of the individual(s) you authorize our office to discuss care with. Your PHI may be disclosed to the individual(s) listed below until you notify us otherwise in writing.

_____ _____

_____ _____

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient, but it could not be obtained because:

- The patient refused to sign.
- Due to an emergency situation, it was not possible to obtain an acknowledgement.
- We were not able to communicate with the patient.
- Other *(Please provide specific details)*

_____

_____ _____

Employee signature *Date*