 **BELLBROOK FAMILY PRACTICE**

 **Patient Acknowledgement and Consent Form**

Please sign this form below to acknowledge that you have reviewed a copy of our Notice of Privacy Practices and to consent to our disclosures of your information that we deem necessary in order to provide you with proper treatment.

I acknowledge that I have been given an opportunity to review the Notice of Privacy Practices of Bellbrook Family Practice. I consent to your disclosures of my information, which you deem are necessary in connection with my treatment. I understand I may request a copy of the Privacy Notice at any time.

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Patient Signature Patient Name (please print) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature Date

**Release of Information**

I also give consent for my treatment and financial information to be discussed with the following individuals: (e.g. spouse, parent, caregiver, etc.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ( ) - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Phone Relationship

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ( ) - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Phone Relationship

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ( ) - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Phone Relationship

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Patient Signature Date

**HIPPA Contact Questions**

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your voicemail at home or on your cell phone? YES NO

May we leave a message at your place of employment? YES NO

Bellbrook Family Practice Employees can be identified as the caller? YES NO