Ascentist Healthcare LLC

Patient Name: _____ Date of Birth: _____

HIPAA

1) **Notice of Privacy Practices**

* You have the legal right to review the Notice of Privacy Practices before signing this form. This is available to view in the Reception area. A personal copy is available upon request.
* The Notice of Privacy Practices is subject to change. A revised copy may be obtained by calling 816-875-2595 or visiting www.ascentist.com

2) Disclosures of **Protected Information**

* You have the right to designate personal representatives who we may release information to regarding your care. We are not required by law to comply with this request, however if we agree we are bound to this agreement.
* Ascentist Healthcare, LLC may disclose protected health information without your consent for the purpose of continued treatment, payment, health care operations and as required by Law.
* You may skip this section if you do not want designate any personal representatives.
* Types of access **Financial:** This may include balance on account status and insurance info, as well as clinical and appointment information.
Appointment: This may include past, present and future confirmation of appointment dates and times.
Clinical: This may include, but not limited to, Diagnosis, Treatment Plan, and Medications

Name	Date of Birth	Relationship	May Access: Check all that apply
_____	_____	_____	☐ Financial ☐ Appointments ☐ Clinical
_____	_____	_____	☐ Financial ☐ Appointments ☐ Clinical

COMMUNICATIONS

1) **Detailed messages may be left on my voicemail or with the person answering the call**

* This includes, but is not limited to information regarding treatment, test results, or financial information. ☐ Yes ☐ No

2) **Appointment reminders**

* Appointment reminders are automated therefore messages may be left on voicemail or with the person answering the call regardless of the response to #1-Detailed Messages.
* How do you want to receive reminders? ***Select One***

☐ Call Me ☐ Text Me ☐ Email Me at _____ ☐ Refuse Reminders

3) **Marketing**

* At times, our office may send our patients marketing information regarding special events, services or products we offer.
* You have the right to opt out of these mailings. ☐ Include me in mailings ☐ Opt Out

OFFICE / FINANCIAL POLICIES

I have read and understand the Office/Financial Policies provided to me by Ascentist Healthcare, LLC. I understand it is my responsibility to comply with these policies.

ACKNOWLEDGEMENT

* This form will only expire in the event the patient reaches age of majority or upon written request from the patient to change information.
* By signing this form, I acknowledge that I understand and agree to the terms within.

_____ _____

Patient / Legal Representatives Signature *Date*

_____ _____ _____

Legal Representative- Printed Name *Legal Representative- Relationship to patient* *Staff Initials and Date*