

Hopewell Health Centers, Inc.
Patient Acknowledgement Form for
Receipt of Health Information Privacy Practices

I, understand that as part of my (or my child's) health care, this office keeps health records describing my health history, a list of symptoms or medical problems, details on the doctor's examination of me, results from tests that I've had, my diagnosis, treatment, and any future plans for treatment. I understand that this record serves as:

- A way for my health care provider to plan my care and treatment
- A way for all the health professionals involved in my care to have the same information
- Information that can be given to my insurance company or the agency paying for my care so they can make sure I received the services that Hopewell Health Centers billed for,
- And as a way for Hopewell Health Centers to make sure they are providing me with the best care possible.

I have also been offered a copy of the *Notice of Information Privacy Practices* that tells more about the items listed above. I understand that if I have any questions either now or in the future about this information, I can talk to a staff member.

If I am attending a Behavioral Health appointment I have been offered a copy of the *Consumer Handbook* which also contains client's rights information.

Patient/Guarantor Signature _____

Date _____