ADELANTE HEALTHCARE

PATIENT ACKNOWLEDGEMENT FORM

AA15.PT.FRM

You may refuse to sign this acknowledgement and authorization. By refusing we *may not be allowed* to process your insurance claims.

The Health Insurance Portability and Accountability Act ("HIPAA") requires us to provide you with notice of our privacy practices. The privacy notice includes our policies on reviewing, amending and/or copying your protected health information (PHI).

Our goal is to protect your privacy, and we encourage you to read the notice of our privacy practices.

The undersigned acknowledges review of and was offered a copy of the currently effective Notice of Privacy Practices

A copy of this signed and dated document shall be as effective as the original. By signing this Patient Acknowledgement Form, you acknowledge and authorize, that this health care provider may recommend products or services to promote your improved health. This health care provider may or may not receive third party remuneration from these affiliated entities. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Adelante may contact me through phone, email, and text about special services, events, fund raising or new health information or services. We may make your information available electronically through an electronic health information exchange ("HIE") to other health care providers and health plans that request your information for their treatment and payment purposes. For more information please ask health center staff about HIE. If I wish to opt out of these communications – I need to notify the Privacy Officer by mail at 3033 N Central Ave, Ste. 145, Phoenix, AZ 85012 or email at privacyofficer@adelantehelathcare.com

Adelante Healthcare Patient Rights and Responsibilities was given to me and I had the opportunity to have it read to me or interpreted in my preferred communication method. I have had the opportunity to ask questions, and I understand my Rights and Responsibilities as a patient of Adelante Healthcare.

Patient Signature _____ Date of Birth _____ Date _____

Please Print Name _____ Parent or Guardian Signature Consent (If under the age of 18 years old) _____

Legal Representative [if applicable] _____ Description of Authority _____

Your comments or special requests regarding Acknowledgements or Consents:

This form is required to be scanned to patient chart.