We look forward to meeting you! Please fill out the forms in this packet and return them to us prior to your appointment. If you need help, we are happy to assist you.

Your Welcome Packet includes the following forms:

- Registration form
- Contact information
- Patient-Centered Medical Home (PCMH) information
- Consent to Care Management
- Consent to Virtual appointments
- Notice of Privacy Practices
- Authorization for release of information from your previous primary provider to HIFM

At your first appointment, we will focus on building your child's health record and understanding his or her medical needs. Bring the following items to your first appointment so your time will be well spent, and to allow us to provide the best possible service!

What to bring to your first appointment

- **Medications** - All of your current medications in labeled bottles. Include all prescriptions, vitamins and supplements. Yes, we want to see the actual pills and labels!
- **Allergies list** - A list of all drug allergies and side effects that you have had.
- **Medical history** - A list of all medical problems and surgeries that you have had during your lifetime.
- **Medical records** - Copies of all medical records that you have available, including vaccination records.
- **Advance directive** - Your advance directive (living will) and Designation of Patient Advocate (medical power of attorney), if you have them.
- **Doctors' information** - The names, addresses and telephone numbers of all doctors that you have seen in the past 12 months.
- **Your questions** - A list of questions you or your child may have about their health.
- **Insurance information** - Your insurance information. We want to see your current insurance card at every appointment.

--- Thank you, from your Hastings Internal and Family Medicine team !

PATIENT FINANCIAL POLICY

Your understanding of our Patient Financial Policy is very important. While your health is our first priority, payment for services in accordance with this financial policy is necessary to maintain a relationship with you. Please contact us immediately if you have any questions or concerns about payment for services.

Insurance. We participate with most insurance plans, including Medicare. If you are NOT insured by a plan we do business with, payment in full is expected at each visit. Knowing your insurance benefits is your responsibility. Please contact your insurance company with questions you may have regarding your coverage.

Coverage changes. We request that you notify us promptly of any changes in your insurance, your legal name, address, or phone number. If we do not have up to date information at the time of your appointment, your insurance company will deny payment and you will be responsible for the entire cost of your visit. Late payment penalties may apply. If your insurance changes, please inform us before your next appointment so you can receive your maximum insurance benefits.

Proof of insurance. To protect you from unnecessary charges, all patients must provide their current valid insurance card at every appointment. This also applies to workers' compensation and auto insurance policies that may need to be billed for your visit.

Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. Your insurance copays and deductibles are an agreement between you and your insurance company. Failure on our part to collect co-payments and deductibles can be considered fraud. Please help us fulfill our obligation by paying the portion you are responsible for at each visit. For your convenience we accept Visa, Master Card, Discover, American Express, money orders, cash, and checks. The charge for a returned check is $35.00 payable by cash or charge only. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned check.

Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for any non-covered services, and you will receive a statement for these services if not paid at the time of your appointment.

Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly to them. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility. Your copays, deductibles and covered services are part of the contract between you and your insurance company, over which Hastings Internal and Family Medicine has no control.

Nonpayment. Past due accounts will be sent up to three monthly statements. If payment is not received or if payment arrangements are not made after the first statement, a $10 handling fee will be added to each additional statement. If payment is not received after the third statement, you will receive a collection letter and/or a phone call to make payment arrangements, and your account may be referred to a collections agency. If you are referred to collections, you will also be discharged from the practice, and will be notified by regular and certified mail that you have 30 days to find alternative medical care.

Self-Pay. Payment is required in full at the time of visit by accounts who are self-pay. Self-pay accounts are those without insurance coverage, or without an insurance card on file with us. If your insurance information is incorrect and we are unable to bill your insurance company, you will be considered self-pay. If you are self-pay and have difficulty paying at the time of service, please ask to speak to our billing supervisor to discuss a payment plan.

Minors. The parent(s) or guardian(s) is responsible for full payment on their minor child. We ask that you send your child with payment for their appointment or call our office ahead of time and pay over the phone. A signed release to treat may be required for unaccompanied minors.
Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are responsible to pay for services. Our office will not bill any other personal party.

Prices for services. Payments we receive for most services are determined by agreement with insurance companies and governmental payors such as Medicare and Medicaid and are less than the "list price" that may appear on your statement. Prices charged are representative of the usual and customary charges for our area.

Cancellation and No-Show policy. When you schedule an appointment with Hastings Internal and Family Medicine, we set aside time specifically for you with one of our providers. In order to serve all of our important patients well and in a timely manner, it is important that you keep your scheduled appointment with us and arrive on time.
As a courtesy, and to help patients remember their scheduled appointments, Hastings Internal and Family Medicine sends text messages, emails and or phone calls in advance of the appointment time. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment.

- Patients who miss an appointment or do not cancel with **at least 24 hours' notice** will be charged a **$25.00 fee.**
- Patients with repeated missed appointments may be **dismissed** from the practice.

We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. In these cases, the fee may be waived. Please let us know as soon as possible if this occurs. You may contact Hastings Internal and Family Medicine 24 hours a day, 7 days a week at 269-948-0078.
I have read and understand the Patient Financial Policy and agree to abide by its terms and conditions.

Patient name printed: ___________________________________ Date of birth: _____________

Patient or parent/guardian signature: ____________________________ Date: _____________

Pediatric Patient Registration *(requires signature)*

IMPORTANT: YOU MUST LIST ALL INSURANCES

Child's Last Name: _________________________ Middle Initial: ______ First Name: __________________Birth date: ____________

Childs Address: _______________________________________ City: _____________________ State: ______ Zip: ________________

Social Security # ____ Gender at birth: Male Female

Gender identity: ____________________________________ Preferred pronouns: (if any) __________________________________

Fathers Name: ____ Birth date: _______________________________

Home phone #: _______________________________________ Cell phone #: ____

Fathers Address: ____ City: ____________________ State: ______ Zip: ______________

Social Security #: _______________________________ Employer: ____

Insurance Carrier (if child is covered under policy): ____

Insurance Contract #: ____ Group #: ____________________________________

Mothers Name: ____Birth date: ______________________________

Home phone #: _______________________________________ Cell phone #: ____

Mothers Address: ____ City: ____________________ State: _____ Zip: ______________

Social Security #: ______________________________ Employer: ____

Insurance Carrier (if child is covered under policy): ____

Insurance Contract #: ____ Group #: ____________________________________

Legal Guardian other than Father and Mother

Name: ____ Birth date: ___________________ Phone #: ___________________

Address: ____ City: ________________________ State: ____ Zip: ____________

Other Insurance

Insurance Carrier: _________________________________ Contract#: _____________________________ Group #: ______________

Name of Subscriber: _____________________________________ Birth date: __________________ Relationship: _______________

Insurance Carrier: _________________________________ Contract #: _____________________________ Group #: ______________

Name of Subscriber: _____________________________________ Birth date: __________________ Relationship: _______________

ASSIGNMENT OF INSURANCE BENEFITS

I, the undersigned, authorize payment of authorized insurance benefits be made on my behalf to Hastings Internal and Family Medicine for any services provided by this organization.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits Payable for related equipment or services to the organization, the Health Care Financing Administration, my insurance carrier or other medical entity if requested.

I understand that I am financially responsible for any charges not covered by my child's health care benefits. It is my responsibility to notify Hastings Internal and Family Medicine of any changes in my child's health care coverage.

SIGNATURE: ____ Date: _______________________________________

Printed name and relationship to the patient: ____

Pediatric Emergency Contacts and Authorizations (requires signature)

Child's Last Name: ___________________________ First Name: ___________________________ Birth date: ___________________

Emergency Contact 1: ____

Relationship: _______________________________________ Phone #: ____

Emergency Contact 2: ____

Relationship: _______________________________________ Phone #: ____

AUTHORIZATION FOR NON-PARENT TO MAKE MEDICAL DEISIONS FOR MINOR CHILD

I authorize the following person(s) to bring my child to Hastings Internal and Family Medicine and make medical decisions for their care. (Please include any step parents)

Name: _____________________________________ Relationship: _______________________ Phone #: ____________________

Name: _____________________________________ Relationship: _______________________ Phone #: ____________________

Name: _____________________________________ Relationship: _______________________ Phone #: ____________________

AUTHORIZATION TO TREAT A MINOR CHILD AGE 16 OR OLDER WITHOUT PARENT OR GUARDIAN PRESENT

(For minor child age 16 or older please choose one below)

☐ **APPROVED.** When I am not here with my minor child age 16 or older the providers and staff of Hastings Internal and Family Medicine may give medications, perform procedures that are also needed for the health of my child and treat. I am aware that copays and deductibles may apply with my insurance, and that I will be responsible for the amount due.

☐ **DECLINED.** I decline to allow my minor child age 16 or older to come to appointments without a parent or guardian present.

SIGNATURE: ____ Date: _______________________________________

Printed name and relationship to the patient: ____

I understand that I have the right to revoke this authorization in writing at any time by sending such written notification to the practice's Privacy Contact at: Hastings Internal and Family Medicine 225 S M37 Hwy, Suite 1 Hastings, MI 49058. I understand that a revocation is not effective to the extent that my physician has relied on the use of disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I understand the above family members and/or friends may have limited access to my child's protected health information. I understand that I may revoke or change this consent at any time. I understand that it is the responsibility of the parent or guardian to maintain this list of names**. Any updates or changes require a new consent form be completed and signed by the biological parent/guardian ONLY**. I understand that the biological mother and father are always permitted to have access to my child's protected health information unless the parental rights of either the father or mother have been legally terminated.

SIGNATURE: ____ Date: _______________________________________

Printed name and relationship to the patient: ____

Patient-Centered Medical Home (requires signature)

Hastings Internal and Family Medicine is a level III NCQA certified Patient-Centered Medical Home

What is a Patient-Centered Medical Home?

A "Patient-Centered Medical Home" is a home for all of your health care needs. We serve as the center of your healthcare, coordinating all medical services no matter where they are provided. We are your home because we care about you, and will work personally with you to be as healthy as possible. And if we can't provide the service you need, we'll help you find a medical provider or specialist who can.

The Medical Home model is a team-based approach to care. The team is led by Physicians and includes Mid-level providers, Medical assistants, and Care Managers who work together with you to make sure your individual needs are met.

As a member of this medical home, you have a right to expect privacy, quality and respect. In return, we expect you to do your best to provide all necessary information, follow recommendations and live a healthy lifestyle. In this way, we believe you can achieve your best possible health.

As your Medical Home, we will:

- Treat you and your family with respect and consideration.
- Give you complete access to all of your health information.
- Provide the best possible advice and treatment based on current medical evidence.
- Help you to develop and carry out your own personal health care goals.
- Give recommendations for a healthy lifestyle.
- Provide treatment for acute illness and long term disease.
- Direct you to high quality specialists and other care providers as needed.
- Provide 24-hour access to care via the patient portal, the answering service and local Urgent Care. If needed, the emergency department can be used (for emergencies only).
- Provide same day appointments, whenever possible.
- Listen to your suggestions and work to improve our services to better meet your needs.

What we ask of you:

- Contact us ***first*** with new health care needs, unless it is a medical emergency.
- Keep all scheduled appointments.
- Carefully consider our medical recommendations including testing, treatment, vaccinations, and routine screening, and inform us if you do not agree with or will not be able to follow the recommended plan.
- Recognize the impact of your lifestyle on your personal health.
- Request additional information when you do not fully understand your condition or your provider's instructions.
- Provide all pertinent information about past illnesses, hospitalizations, medications, and other health related matters.
- Provide a copy of your advance directive and medical power of attorney, if you have one.
- Be considerate of the needs of other patients in the office and our office staff.
- Make required payments at the time of service, and provide all needed information for insurance claims.

Working together

We pledge to do our best as your healthcare provider. Despite this, there may be times when we do not fulfill your expectations. Please let us know as soon as possible if you feel we have missed something important or have failed to provide good service. While we try to do a great job, we need your help to keep our standards high.

Ending the partnership:

At times, a doctor-patient relationship may suffer from lack of mutual trust, poor communication, or failure to fulfill the terms of this agreement.

If this occurs, either the patient or the physician may choose to end the partnership, and request that further health care be obtained elsewhere. Hastings Internal and Family Medicine provides patient records for transfer of care at no charge.

I have read the above and agree to participate in the Patient-Centered Medical Home.

SIGNATURE:

____

Authorized Signature **Printed name and relation to patient (if applicable)** **Date**

Consent to Care Management (requires signature)

Care Managers are trained Registered Nurses and others who coordinate services for patients with complex and chronic conditions or life issues that impact their health. Care Managers help patients have a better health care experience, better health outcomes, and reduced expenses for medical tests and treatment.

Care Managers provide the following services:

- Help you understand and follow your medical plan of care as directed by your provider.
- Learn *your* concerns and priorities to inform your provider about what is most important to you.
- Work with you one-on-one or in a group setting to overcome barriers that prevent you from reaching your personal health goals.
- Coordinate services among medical providers such as hospitals, specialists, home care services and personal care givers and pharmacies.
- Inform you about advance directives and other important decisions that impact your future.

Care Management services are paid for by your insurance, including Medicare, Blue Cross and Priority Health. Depending on your insurance, a copay may be required. Only one medical office may deliver Care Management services for any patient at a time. You may discontinue Care Management services at any time by notifying your provider.

At Hastings Internal and Family Medicine, we believe that Care Management improves the care you receive from our practice, and will improve your health! Please ask your provider or any staff member if you have questions about Care Management services.

I understand that Hastings Internal and Family Medicine will provide me with Care Management which may include office visits, telephone visits, chart reviews, and coordination of services from other providers. I understand that my health information may be requested from and shared with other providers for care coordination purposes. I further understand that I may refuse any Care Management service at any time.

SIGNATURE:

____

Authorized Signature **Printed name and relation to patient (if applicable)** **Date**

Consent to Virtual Appointments (requires signature)

Virtual Appointments are face-to-face confidential encounters with Hastings Internal and Family Medicine providers provided through an electronic interface, such as a smart phone or web cam using encrypted software.

Virtual Appointments offer several benefits:

No need to drive in to the medical office.
Save time and money compared to regular visits.
Increased privacy as your visit can be done from your home or car.
Easier access for patients with limited mobility.

There are a few disadvantages:

Your provider can perform only a limited physical examination.
Some medical problems are not suitable for Virtual Appointments.
Not all insurances cover Virtual Appointments.

Hastings Internal and Family Medicine is obligated to provide a secure and private environment for the appointment, and to use software that is fully HIPAA compliant. It is the patient's obligation to ensure privacy on his or her end of the secure connection.

Virtual Appointments may result in specific recommendations by the provider including prescription or over-the-counter medications, lab testing or x-ray, referral to a specialist, or scheduling an in-office appointment.

Your Virtual Appointment will be permanently documented in your personal electronic health record.

It is possible that technical difficulties with the interface could interrupt the appointment. If this occurs, both the provider and the patient agree to attempt to reestablish the connection, and if this cannot be done, will reconnect by telephone.

If you have insurance coverage for virtual visits, your insurance company will be billed. If there is no coverage you will be asked to pay for the visit with a credit card at the time of the visit.

I understand the benefits and disadvantages of Virtual Appointments and agree to the terms described above. I understand that participation in Virtual Appointments is optional, and any Virtual Appointment will only be scheduled with my consent.

SIGNATURE:

____

Authorized Signature **Printed name and relation to patient (if applicable)** **Date**

Notice of Privacy Practices – Hastings Internal and Family Medicine

This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information. Please review it carefully.

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.) that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is legally required to maintain the confidentiality of your PHI, and to follow specific rules when using or disclosing this information. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules when using or disclosing your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Rights Under The Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices - We are required by law to follow the terms of this Notice. We reserve the right to change the terms of the Notice, and to make the new Notice provisions effective for all PHI that we maintain. We will provide you with a copy of our current Notice if you call our office and request that a copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location in the practice, and if such is maintained, on the practice's web site.

You have the right to authorize other use and disclosure - This means we will only use or disclose your PHI as described in this notice, unless you authorize other use or disclosure in writing. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication – This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, fax, telephone), and/or to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and obtain a copy your PHI* - This means you may submit a written request to inspect or obtain a copy of your complete health record, or to direct us to disclose your PHI to a third party. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable, cost-based fee for paper or electronic copies as established by federal guidelines. We are required to provide you with access to your records within 30 days of your written request unless an extension is necessary. In such cases, we will notify you of the reason for the delay, and the expected date when the request will be fulfilled.

You have the right to request a restriction of your PHI* - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You have the right to request an amendment to your protected health information* - This means you may submit a written request to amend your PHI for as long as we maintain this information. In certain cases, we may deny your request.

You have the right to request a disclosure accountability* - You may submit a written request for a listing of disclosures we have made of your PHI to entities or persons outside of our practice except for those made upon your request, or for purposes of treatment, payment or healthcare operations. We will not charge a fee for the first accounting provided in a 12-month period.

You have the right to receive a privacy breach notice - You have the right to receive written notification if the practice discovers a breach of your unsecured PHI and determines through a risk assessment that notification is required.

* If you have questions regarding your privacy rights or would like to submit any type of written request described above, please feel free to contact our Privacy Manager. Contact information is provided at the bottom of the following page.

How We May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

Treatment - We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

Payment - Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations - We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Special Notices - We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests, to provide information that describes or recommends treatment alternatives regarding your care, or to provide information about health-related benefits and services offered by our office.

We may contact you regarding fundraising activities, but you will have the right to opt out of receiving further fundraising communications. Each fundraising notice will include instructions for opting out.

Health Information Organization - The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

To Others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of PHI (e.g., in a disaster relief situation), then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosures - We are also permitted to use or disclose your PHI without your written authorization, or providing you an opportunity to object, for the following purposes: if required by state or federal law; for public health activities and safety issues (e.g. a product recall); for health oversight activities; in cases of abuse, neglect, or domestic violence; to avert a serious threat to health or safety; for research purposes; in response to a court or administrative order, and subpoenas that meet certain requirements; to a coroner, medical examiner or funeral director; to respond to organ and tissue donation requests; to address worker's compensation, law enforcement and certain other government requests, and for specialized government functions (e.g., military, national security, etc); with respect to a group health plan, to disclose information to the health plan sponsor for plan administration; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Privacy Complaints

You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. We will not retaliate against you for filing a complaint.

You may ask questions about your privacy rights, file a complaint or submit a written request (for access, restriction, or amendment of your PHI or to obtain a disclosure accountability) by notifying our Privacy Manager at:

Hastings Internal and Family Medicine

225 S M-37, Suite 1, Hastings, Michigan 49058
Telephone (269) 948-0078
www.HastingsMedicine.com

SIGNATURE:

Authorized Signature **Printed name and relation to patient (if applicable)**
Date

Authorization for Release of Medical Information to Hastings Internal and Family Medicine

Patient Name | Date of Birth | Today's Date

I authorize ______________________________
Name of Practice or Individual

____
Address

____
Telephone Number | Fax Number

to disclose or provide the following protected health information about me to:

Hastings Internal and Family Medicine
225 S M-37, Suite 1
Hastings, MI 49058
Fax 269-948-0099

☐ Entire patient record; (or, check only those items of the record to be disclosed below)

- ☐ Office/Consult notes
- ☐ Lab/X-ray results, pathology reports,
- ☐ Financial History
- ☐ Immunization record
- ☐ Immunization record
- ☐ Medical Summary
- ☐ Confidential record of HIV and communicable disease testing
- ☐ Confidential records of mental health or substance abuse treatment
- ☐ Only the following:______________________________
- ☐ Dates: ______________________________

Purpose for release:
- ☐ Transfer of care
- ☐ Continuing care or consultation
- ☐ Request of patient or legal representative

- This release is effective for one year from the date of signature. It may be revoked at any time by providing written notice to the practice or individual listed above.
- A facsimile or photocopy of this document may be accepted in lieu of the original.
- Medical records released to Hastings Internal and Family Medicine are subject to privacy protections under the Health Insurance Accountability and Portability act, and may not be further released without specific written authorization.

____
Signature of Patient or Legal Representative | Relationship to patient if applicable | Date

____
Signature of Witness | Date

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www.HastingsMed.com