NEW ENGLAND CENTER for MENTAL HEALTH

ADULT OR MATURE/EMANCIPATED MINOR PATIENT
ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

Patient Name: _____
Last First Middle

Home Address: _____

_____

Home Telephone: _____ Date of Birth: _____

ACKNOWLEDGEMENT OF RECEIPT OF NEW ENGLAND CENTER for MENTAL HEALTH (the "PRACTICE") NOTICE OF PRIVACY PRACTICES:
By my signature below, I hereby acknowledge that I have received a copy of the Practice's Notice of Privacy Practices.

CONSENT TO DISCLOSE MY GENERAL HEALTH INFORMATION:
By my signature below, I hereby authorize the Practice to disclose my medical information so that the Practice may treat me, seek payment from third parties for such treatment, and generally carry on the Practice's health care operations (e.g., quality assurance). I also authorize the Practice to disclose my medical information to insurers and providers outside of the Practice when necessary so that these providers may treat me, seek payment for that treatment, and for the purpose of their health care operations.

I authorize the Practice to disclose my medical information on (check one, or fill in preferred method):

_____my home answering machine

_____my cell phone voicemail

_____other method, describe: _____

I authorize the Practice to disclose my health information to the following family members/friends (I understand I may instruct Pediatrics West, P.C. to limit disclosure of my health information to family members and/or their insurance plans but by doing so my family's health plan cannot be billed for my visit or test and I shall be financially responsible to pay all charges directly):

_____

ASSIGNMENT OF INSURANCE BENEFITS:
By my signature below, I authorize medical benefits to be paid to Pediatrics West, P.C. on my behalf for any service provided by the medical and clinical staff of the practice. I understand that I am responsible for all charges, regardless of insurance coverage, for this service date as well as all future service dates.

ASSIGNMENT OF RECEIPT OF PRACTICE'S BILLING POLICY:
By my signature below, I hereby acknowledge that I have received a copy of the Practice's Billing Policy.

_____ _____ _____
Signature of patient who is over 18 years old or minor/emancipated minor | Description of Authority | Date