201 W. Boiling Spring Rd.
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NEW HOPE CLINIC, INC.

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Patient Agreement / Acknowledgement of Receipt of Privacy Practices

PATIENT NAME:_____ DATE OF BIRTH:_____

I acknowledge and fully agree to the following matters: (initial by each item)

____ 1. I understand that New Hope Clinic, Inc. is an independently operated charitable organization that is funded through grants and individual donations. I understand that health care services provided at the New Hope Clinic, Inc. are subject to change due to availability of funding and staff. Services available at New Hope Clinic will be provided free of charge, including visits with our healthcare providers, medications from our limited pharmacy, and tests performed on site. In the event that unavailable services are prescribed, New Hope Clinic will try to arrange for services to be provided a no or reduced cost. I understand that payment for these services is my responsibility and New Hope Clinic is not able to pay for these outside costs. These outside costs may include, but are not limited to, some medications, testing, specialty appointments, and emergency treatment.

____ 2. Good communication between patients and the Clinic is the key to better health & outcomes. New Hope Clinic is committed to providing patients the highest quality healthcare. This can best be accomplished by a clear understanding about the Clinic's responsibilities to patients, and the rights and responsibilities of a Clinic patient. I confirm that I have received the New Hope Clinic, Inc. Patient Handbook dated 5/22/2017 and am responsible for following the guidelines in the handbook. If I do not follow these guidelines, I may be terminated from NHC.

____ 3. I, (the patient) am ____ years of age and I am either able to read this, or I have had this document read to me by the witness/reader whose name appears below.

Privacy Practices: It is required that we protect the privacy of health information of our patients. You may request that only certain individuals (usually close family or friends) be given information about your health, treatment or other personal information. You can also request how New Hope Clinic, Inc. communicates information to you.
We need to have a way to contact you or leave a message during day time hours.

Please contact me in the following manner:

Home Phone #: _____ It is OK to leave detailed information on voice mail? Y___ N ___
It is OK to leave detailed information with a person? Y___ N___ Name of individuals:_____

Cell Phone #: _____ Is it OK to leave detailed information on voice mail? Y___ N___

Work Phone #: _____ Is it OK to leave a detailed message on personal voice mail? Y___ N___
*** Messages will not be left with a person at work unless you have specifically indicated the name of the person in the following space: _____

Emergency Contact Name:_____ Relationship:_____#: _____
Is it OK to leave a message with someone or on voicemail? Y___ N___

If the above are answered NO, a message will be left only stating that our office called and a name and call back number will be left. All correspondence mailed to you will be in a sealed envelope addressed only to you.

I authorize New Hope Clinic, Inc.'s staff to discuss my Protected Health Information with the following individuals:

Name (Please Print)	Relationship to Patient
_____	_____
_____	_____
_____	_____

I acknowledge that I have been given the opportunity to read New Hope Clinic, Inc.'s Notice of Privacy Practices and understand that the above will remain in effect until revised by me.

Date	Time	Patient/Legal Guardian Signature	Printed Name
Date	Time	Reader/Witness Signature	Printed Name