ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge I have received a copy of ARCK's Notice of Privacy Practices.

I give permission for ARCK to leave a message on my answering machine or with a third person who answers my telephone concerning a scheduled appointment reminder.

Check one: ☐ **Yes** ☐ **No**

If yes: **Telephone Number to be called:** _____

Alternate Number to be called: _____

We often are contacted by a patient's family member or friend and asked to report on the patient's condition, or to provide information concerning charges and payment for services provided. If you are present at the time a family member requests such information, we may ask you whether you want us to share information with your family member or friend. If you are not present at the time such a request is made by a family member (e.g., over the phone), we will follow your prior instructions in determining whether we should share any information. If you have not provided any such instruction, we will contact you before providing any specific response to an inquiry from a family member or friend.

Concerning payment: I give permission for ARCK to discuss insurance, billing and accounting issues with the following person:

Name: _____ **Relationship:** _____

Please check the following:

☐ Do **not** share information with family members except in emergency situations

☐ Share information with my spouse only, unless I specifically direct you not to share certain information with my spouse.

My spouse's name is: _____

☐ Share information with the following family members or friends upon their request, unless I specifically direct you not to share certain information:

NAME	**RELATIONSHIP**
_____	_____
_____	_____

_____ _____

Signature of Patient or Patient Representative Relationship to Patient

_____ _____

Type Patient Name Date