Basic Demographics Privacy Practices, and Rights and Responsibility

Name: (Last)_____ (First)_____ (MI) _____ Date of Birth: _____

Printed Name of Parent or Legal Guardian (If applicable): _____

Notice of Privacy Practices Acknowledgement

I understand that under the **Health Insurance Portability & Accountability Act of 1996 (HIPAA)**, I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

*Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.

*Obtain payment from third-party payers.

*Conduct normal healthcare operations such as quality assessments and physicians certifications.

I understand that this organization has the right to change its NOTICE OF PRIVACY PRACTICES from time to time and that I may contact this organization at any time to obtain a current copy of the NOTICE OF PRIVACY PRACTICES.

I received a copy of your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my PHI. I have read the document and understand the information.

Notice of Rights and Responsibilities Acknowledgement

I understand that this organization has the right to change its NOTICE OF RIGHTS AND RESPONSIBILITIES from time to time and that I may contact this organization at any time to obtain a current copy of the NOTICE OF RIGHTS AND RESPONSIBILITIES. I received a copy your NOTICE OF RIGHTS AND RESPONSIBILITIES containing a more complete description of the guidelines of rights and responsibilities I have while a patient. I have read the document and understand the information.

Signature: _____ Date: _____

Witness Signature: _____ Date: _____

If you do not agree with these terms, we will be unable to serve as your provider.

Basic Demographics **Self-Declaration of Income**

Name: (Last)_____ (First)_____ (MI) _____ Date of Birth:_____

Printed Name of Parent or Legal Guardian (If applicable): _____

Are you eligible for a DISCOUNT on your health care costs?

How many people are in your household: _____

(Number of people you are financially responsible for in your home or number of people you claim on your taxes.)

How much is your TOTAL household monthly income?

(Please circle an amount closest to your monthly income)

0	500	1000	1500
2000	2500	3000	3500
4000	4500	5000	

Other:_____

If we find you eligible for any discount or assistance program we offer, verification of all income must be on file before any benefit could begin.

Basic Demographics Community Survey

How did you hear about us? Please circle all those that apply:

Facebook Billboard Website Radio

Newspaper Pamphlet Friend/Relative

Other: (Please Specify) _____

What do you like about us? Please circle all those that apply:

Staff Cleanliness Location Speed Atmosphere Cost

Other: _____

How did you arrive at your appointment today? Please circle one of the following:

Drove own vehicle Friend/Relative Bus/cab Walk

Do you have any suggestions to improve your visit with us?

1._____

2._____

3._____

Thank you for taking time to complete our survey. Your input is greatly appreciated.