PATIENT NAME: _____

WRITTEN ACKNOWLEDGEMENT

I acknowledge that I have reviewed the **Notice of Privacy Practices** which provides a description of information uses and disclosures. I understand that I have a right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to the restrictions I request. _____ Initials

I (WE) AGREE AND UNDERSTAND:

1. That each purchase I instruct to be charged to my account is to be recorded on a charge slip or such other form as the Clinic may use from time to time, and if accepted by the Clinic, It is referable to this agreement.
2. A statement will be sent to me detailing the charges, payments, and credits entered on my account during the month preceding the closing date of the statement. The total amount owing at that time will be indicated by the entry new balances.
3. (a.) I may pay the balance in full within 30 days of the closing date of the statement.
   (b.) If I do not pay the full amount within 30 days of the closing date of each statement, I will pay the amount due according to a payment schedule.
   (c.) I may pay the total balance due at any time.
4. If monthly payments become past due, I agree to pay the total amount owing upon demand and to pay reasonable collection costs, attorney fees and court cost as permitted by law if such are incurred by the Clinic.
5. I understand delivery of this disclosure statement does not indicate the amount I am applying for has been approved, and that I will be informed of any such approval separately.
6. I have received a copy of Bullhook Community Health Center's Rights and Responsibilities and agree to follow these guidelines.

I hereby authorize the Bullhook Community Health Center to release to the company which has insured me, all information regarding treatment by my doctor, and I further assign to the Bullhook Community Health Center all medical and surgical benefits payable under said policy. I further agree to pay the Bullhook Community Health Center for any charges for professional services not covered by my insurance. _____ Initials

NOTICE OF ADMINISTRATIVE USE OF CONFIDENTIAL HEALTH CARE INFORMATION

I have been informed and understand that:

(1) confidential health care information concerning me or the person for whom I am legally responsible provided or recorded in the course of receiving immunization, family planning, and/or maternal-child health client case management services from this Health Center is electronically recorded and retained in the Montana Immunization registry.
(2) unless I specifically direct otherwise, the immunization information in Montana immunization registry will be shared with all my immunization providers to help prevent both over- and under-immunization and to create a consolidated vaccine record for me or the person for whom I am legally responsible;
(3) any confidential health care information concerning me or the person for whom I am legally responsible may be used for the administration and direct provision of services that are to be provided to me or to the person for whom I am legally responsible;
(4) Health Center Clinic and administrative personnel associated with the delivery of those services and the administration of the programs of services and the data system may access the information as necessary for the provision and administration of services. Administration of services may include, but is not limited to, the billing of insurers, scheduling of appointments, coordinating immunizations, and facilitating enrollment in other programs; and
(5) All persons who have access to this confidential information are obligated under federal and state law to protect the information from inappropriate disclosure.

X _____ _____
Signature of Client or legally responsible person Date

_____ _____
Signature of staff member witness Date Witnessed