ACKNOWLEDGEMENT AND AUTHORIZATION FORM

Patient Name (Print Full name):	*Date of Birth:*

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I acknowledge that I have been provided the *Grand Peaks Notice of Privacy Practices (i.e. the "Notice")*.
The "Notice" informs me of how Grand Peaks facilities will use my health information for:

- Purposes of my treatment, payment for my treatment and health care operations.
- Reasons other than treatment, payment and health care operations.
- Use and share health information as required/permitted by law.

I have been provided the opportunity to ask questions and understand I may request and review the "Notice" at any time. I understand this agreement will remain in effect until revoked from me in writing.

I authorize Grand Peaks facilities to release health information, including all medical records to to the following:

Individual's Name/Facility Name:	Relationship	Phone #(s)/Fax #:
1.		
2.		
3.		

INFORMED CONSENT FOR GENERAL CARE & TREATMENT

I hereby authorize Grand Peaks facilities and its affiliated Providers and staff to examine, test, and treat me or my dependent(s) for any medical, dental and/or behavioral/mental health condition. No guarantees have been made to me regarding my treatment or examination. In case of an emergency, in which I cannot be reached, I further authorize Grand Peaks facilities to treat my dependent(s). This consent is voluntary and will remain valid for <u>two (2) years</u>. You have the right to revoke this consent at any time.

AUTHORIZATION FOR ELECTRONIC COMMUNICATIONS

Grand Peaks facilities may communicate with our patients via electronic communications, which may include email, patient portal, and/or text. All communication is kept strictly confidential. Such communications sent thru the internet or over phone systems may not be encrypted or secure and could result in unauthorized persons retrieving your information. Grand Peaks facilities are not responsible for the device that the patient receives communication on (i.e. phone, laptop, tablet, etc.)

AUTHORIZATION FOR ELECTRONIC RECORDING

Grand Peaks Providers are using a new technology (DAX) to electronically document your encounter based on a recording of your visit. I give my consent for this recording.

AUTHORIZATION FOR FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for any charges incurred and the balance on my account. If I have insurance coverage, I authorize my insurance benefits to be paid directly to the Provider/Upper Valley Community Health Services DBA Grand Peaks facilities. I also authorize Grand Peaks facilities or my insurance company to release any information required to process my claims.

NOTICE REGARDING OUTSIDE LABORATORY TESTING

Grand Peaks has the ability to run many Laboratory tests within our facility, HOWEVER, some testing must be done by an outside Laboratory, LabCorp. LabCorp offers discounts to Grand Peaks patients based on the sliding scale discount you have been assigned by providing income at the time of service. LabCorp will also bill your insurance company. ***Note:** *You will be responsible to pay the remainder of the bill you receive from LabCorp, if you have questions, you must contact LabCorp.*

BEHAVIOR EXPECTATIONS

While a patient waiting to being seen by a provider or helped in any way at Grand Peaks, we require respectful conduct and for you to be courteous to staff and other patients. If your behavior warrants, you may be refused service. Additionally, if anyone accompanying you at your visit exhibits inappropriate behavior, they may be asked to wait for you outside.

I certify that I have read and understand the policies above, including the Informed Consent for General Care & Treatment. I have been given the opportunity to ask questions, and any questions that I have, have been answered to my satisfaction.

_______________	_______________	_______________	_______________
Patient/Authorized Representative Signature	*Printed Name*	*Relationship to Pt*	*Date*