Acknowledgement of Receipt of Notice of Privacy Practices

I ________________________________have been presented with a copy of the MCH ProCare's Notice of Privacy Practices.

____ _________________________
Signature of Patient or Patient's Representative **Date**

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Relationship to Patient

OFFICE USE ONLY
If patient/patient representative refuses to sign acknowledgement please document:

Staff (name and title) ____

Patient's Name ____

DOB _______________________ Plus Account # _________________
File in patient's medical record - must be retained for six years

Authorization to Release Information

MCH ProCare may disclose all or part of my medical record to any insurance company, association, or the Federal or State Government as may be necessary for the completion of all claims.

I hereby authorize payment to MCH ProCare.

I understand that any reimbursement that my insurance company does not cover remains my personal responsibility and that payment is due at the time of service.

I understand that if my account is not paid or that if payment arrangements have not been made then collection proceedings will begin.

I authorize MCH ProCare to treat as may be necessary or advisable in my diagnosis and treatment.

____ _______________________
Signature **Date**