memorial regional health

LOCATIONS:
785 Russell Street ■ Craig, CO 81625 ■ (970) 826-2400
600 Russell Street ■ Craig, CO 81625 ■ (970) 824-3252
750 Hospital Loop ■ Craig, CO 81625 ■ (970) 826-8230
2020 W. Victory Way ■ Craig, CO 81625 ■ (970) 826-8300

ACKNOWLEDGEMENT OF NO SHOW POLICY AND NOTICE OF PRIVACY PRACTICES

It is the policy of Memorial Regional Health to manage no-show appointments in the following manner:

_________ (initial) MRH will attempt to contact and remind patients/parents/guardians of their appointment one (1) to three (3) days prior to their appointment by phone, email and/or text.

_________ (initial) Patients that fail to appear for their appointment will receive notification from MRH.

_________ (initial) Failure to arrive for appointments repeatedly may result in restriction of appointment availability for patient.

I hereby acknowledge that I received MRH Medical Clinic's Notice of Privacy Practices.

Patient Name (Please Print) ____DOB ___________________

Signature ____ Date ___________________

Documentation of Good Faith Efforts

To obtain patient's acknowledgment that they received the provider's Notice of Privacy Practices.

(For use when acknowledgment cannot be obtained from the patient)

The patient presented to the office on __________________________ and was provided with a copy of Covered Entity's Notice of Privacy Practices. A good faith effort was made to obtain from the patient written acknowledgment of his/her receipt of the Notice. However, such acknowledgment was not obtained because:

____ Patient refused to sign.

____ Patient was unable to sign or initial because:____

____ The patient had a medical emergency, and an attempt to obtain the acknowledgment will be made at the next available opportunity.

____ Other reason:____

Signature of Employee Completing Form _____________________________________ Date ___________________

AUTHORIZATION FOR TREATMENT: I authorize treatment for the care of the above-mentioned patient including immunizations.

FINANCIAL POLICY: I authorize the release of any medical information to my insurance carrier. I authorize all insurance payments be made directly to Memorial Regional Health. I understand that I am responsible for all charges incurred by my dependents or myself. Payment is due at the time of service, unless prior arrangements have been made. I agree to pay all reasonable attorney fees and collection costs in the event of payment default to my accounts.

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS AND AGREE TO ALL THE TERMS STATED THEREIN.

Signature ____ Date ___________________