Clinton REGIONAL HOSPITAL

Acknowledgment of Receipt of Notice of Privacy Practices

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

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read and understand the *Notice of Privacy Practices* document containing a more complete description of the uses and disclosures of my health information. I understand that **Clinton Regional Hospital** ("Practice") has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below for a current copy of the *Notice of Privacy Practices* document.

Do we have your permission to:

Leave a message on your answering machine	Yes/No
Confirm appointments by leaving messages or speaking with family	Yes/No
Leave pre-medication reminders (If applicable)?	Yes/No
Speak to household members concerning your care?	Yes/No

Patient Name	Signature	Date
Name/Relationship to Patient	Signature	Date

FOR OFFICE USE ONLY

Practice provided the above-referenced patient with the Practice's Notice of Privacy Practices and this Acknowledgment of Receipt of Notice of Privacy Practices, but could not obtain a signed acknowledgment form because:

Patient or guardiant refused to sign

Emergency situation

Other:_____

Clinton Regional Hospital 4/16/25/2025

Benefits Assignment and Financial Responsibility

Hospital Administrator	Date
Director of Nursing	Date
Medical Director	Date
Quality Director	Date
Additional Staff Member/Title	Date
Additional Staff Member/Title	Date
Additional Staff Member/Title	Date
Additional Staff Member/Title	Date
Additional Staff Member/Title	Date
Additional Staff Member/Title	Date
Additional Staff Member/Title	Date
Additional Staff Member/Title	Date
Additional Staff Member/Title	Date
Additional Staff Member/Title	Date

Clinton REGIONAL HOSPITAL

Benefits Assignment and Financial Responsibility

Last name _____ First name _____ DOB _____

Address _____ SSN _____

RELEASE OF INFORMATION: I authorize **[Provider/Practice Name]** to disclose and release to my insurance carrier(s), including Medicare, Medicaid, Medigap/Supplemental benefits providers, and private insurers, as applicable, any medical and treatment information needed for payment purposes for services rendered. I authorize use of this form for the release of information needed to process claims to all my insurance carrier(s) and its authorized agents. I authorize my provider/practice to act as my agent in helping obtain payment from my insurance companies.

ASSIGNMENT OF BENEFITS: I assign all payments, rights and claims for reimbursement of claims, costs and expenses allowable under my insurance plan(s) directly to my provider or practice for services rendered. I understand I will receive a statement for any balance due by me and I agree to make full payment upon receipt of the statement after insurance has met its obligation.

AGREEMENT OF RESPONSIBILITY: I understand that **COPAYMENT IS DUE AT THE TIME OF SERVICE** (coinsurance and deductibles may also be collected at the time of service). I understand I am financially responsible for charges not covered by my insurance company. I also agree to pay any outstanding balance as well as attorney fees and costs to **[Practice Name]** if this matter is referred to collection.

MEDICARE AUTHORIZATION: If a Medicare beneficiary, I understand my signature requests payment to be made and authorize the release of medical information necessary to pay claims. If 'other health insurance' is indicated in item 9 of the HCFA-1500 Form, or elsewhere on approved claim forms, or electronically submitted claims, my signature authorizes the release of information to insurance companies or its authorized agents. In Medicare-assigned cases, the physician or supplier agrees to accept the charge of determination of the Medicare carrier as the full charge, and I agree I am responsible for deductible, coinsurance and non-covered services. Coinsurance and deductibles are based upon the charge determination of the Medicare carrier.

Patient signature _____ **Print name** _____ **Date** _____