Hawse Health

(304) 897-5915
FAX (304) 897-6216
PO Box 97
Baker, WV 26801
HAWSEHEALTH.COM

Acknowledgements

I acknowledge that I have received and understand E. A. Hawse Health Center's *Payment and Scheduling Policies*. I further understand that E. A. Hawse Health Center may update these policies any time and that I may receive an updated copy by submitting a request in writing.

I acknowledge that I have received and understand E. A. Hawse Health Center's *Notice of Privacy Practices* containing a description of the uses and disclosures of my health information. I further understand that E. A. Hawse Health Center may update its *Notice of Privacy Practices* at any time and that I may receive an updated copy of E. A. Hawse Health Center's *Notice of Privacy Practices* by submitting a request in writing.

I give permission for E. A. Hawse Health Center to release information (including my medical or behavioral health chart/EHR) to the following:

NAME	RELATIONSHIP	PHONE NUMBER

If your child needs to be seen at school or at one of our offices, please list anyone who has permission to bring your child for medical or behavioral health treatment:

NAME	RELATIONSHIP	PHONE NUMBER

May we leave medical information such as test results on your answering machine? ☐Yes ☐No

_____ _____
Printed Patient Name Date of Birth

_____ _____
Patient Signature Date

If completed by patient's personal representative, please print and sign below.

_____ _____
Printed Patient Personal Representative Name Relationship to Patient

_____ _____
Patient Personal Representative Signature Date

☐ Please keep this signature on file should I have to pay for services using my credit card

For E. A. Hawse Health Center Official Use Only

Complete this form if unable to obtain signature of patient or patient's personal representative. E. A. Hawse Health Center made a good faith effort to obtain patient's written acknowledgement of the Payment and Scheduling Policies and Notice of Privacy Practices but was unable to do so for the reasons documented below:

☐ Patient or patient's personal representative refused to sign ☐ Other
☐ Patient or patient's personal representative unable to sign

_____ _____
Printed Employee Name/Signature Date

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