

\_\_\_\_\_  
Last Name                      First Name                      MI



Macon County  
Public Health

\_\_\_\_\_  
Date of Birth

## Acknowledgement Receipt of "Notice of Privacy Practices"

By signing below, I am acknowledging that:

- ☐ I am either the patient or the patient's personal representative and I have received a copy of the "Notice of Privacy Practices" of Macon County Public Health. I understand that I may contact the person named in the "Notice" if I have questions about the content of the "Notice".
- ☐ I understand that if services are rendered to me and I am not eligible for insurance, at the time of service that I will be responsible for any expenses incurred during that visit.
- ☐ All telephone numbers provided may be subject to receiving telephone calls from an automated dialer using a pre-recorded, artificial voice message or live operator call. I give my express consent to receive such phone calls, including any calls made to the cellular telephone number that I have provided

- ☐ I authorize the release of any medical/dental or other information necessary to process this claim for payment. I request payment of benefits to Macon County Public Health and assigned entities or suppliers of services.

OR

- ☐ I have medical/dental insurance but choose not to have them billed for today's services.

\_\_\_\_\_  
Signature of patient or parent/legal guardian/legally responsible person

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to patient

\_\_\_\_\_  
*To Be Completed by Staff*  
*Complete all applicable parts – Please refer to instructions*

*Part 1. Complete if signature requested but not obtained:*

Staff member sought but was unable to obtain an acknowledgment from the patient or the patient's personal representative for the following reason:

- ☐ Patient/personal representative refused to sign form
- ☐ Other \_\_\_\_\_

*Part 2. Complete if patient/personal representative unavailable to sign form on first date of service delivery:*

- ☐ Form mailed/sent to patient/personal representative on \_\_\_\_\_(Date)

\_\_\_\_\_  
Signature of staff member

\_\_\_\_\_  
Date