CORNERSTONE FAMILY HEALTHCARE

845-563-8000 • www.cornerstonefamilyhealthcare.org

Document Acknowledgement Form

Patient Name: ____ **Date of Birth:** _____/_____/_____ **Patient ID#** _____________

By signing each statement below I acknowledge that I have received a full version of each document. I understand that is my responsibility to read each document and ask for clarification or more information if necessary.

	Patient Initials
Assignment of Benefits: I authorize payment of insurance benefits to Cornerstone Family Healthcare (CFH) for medical, dental and/or radiology services provided to me. I authorize the release of medical or other information necessary to determine benefits coverage and eligibility. I understand that I am financially responsible for charges not covered by my insurance. It is my responsibility to notify Cornerstone Family Healthcare of any changes to my health care coverage.	
Notice of Privacy Practices & HIPAA Acknowledgement: Cornerstone Family Healthcare is committed to protecting your Personal Health Information (PHI) and stay in compliance with federal and state laws such as HIPAA. I have received a copy of the Notice of Privacy Practices and understand how my PHI may be used, as well as my rights and Cornerstone Family Healthcare rights regarding PHI.	
Consent to Photograph for Electronic Health Records: I give consent to Cornerstone Family Healthcare to take my photograph to be stored in my electronic health record. This photograph will be used to identify me and help protect me against identity theft.	
Patient Bill of Rights and Patient Rights & Responsibilities: I have received the Patient Bill of Rights and Patient Rights & Responsibilities document. **General BOR:____ Mental Health Services BOR:____**	
Advanced Directives: I have received the information on Advanced Directives. I understand that in order for my Advanced Directives to be honored, I must complete and submit a Health Care Proxy and/or Living Will form that has been provided to me. **General Advance Directives:_____ Mental Health Services Advanced Directives: _____**	
Consent to Release Medical/Dental Information: I hereby give consent to the following individual to have access and obtain copies of my medical/dental information. This includes health history, exam information, tests and lab results. Information will be provided, based on my consent below. **Name:** ______________________________________ **Phone #:** __________________ **Relationship to me:** ______________________ **Note: While you are authorizing the above named person to have access to your records, they are not authorized access to sensitive information, such as HIV Status/Information, Mental Health Information, State Reportable Results, and/or Alcohol and Substance Abuse Information. If you wish to authorize access to those sensitive records, you must sign a separate consent for each request.**	
I will receive text messages from Cornerstone Family Healthcare. Such text messages may include appointment reminders, preventative/diagnosis related care reminders and diagnosis related health education material. This excludes information related to HIV, Substance Abuse & Mental Health. **Initial to OPT IN for text messaging**	
Patient Portal Account Sharing: I authorize the following individual to have access to my patient portal account. I understand that this individual will have unrestricted access to view my health information including diagnoses, medications, HIV status, and mental health and substance abuse related information. This individual will also be permitted to act on my behalf for all portal activities. Name: ____________________________________ Relationship: _____________ Email (required): ____	

By signing below you acknowledge that you are responsible for updating Cornerstone Family Healthcare of any changes relevant to this document.

Witness: Employee Signature: _________________________________ **Patient Signature:** _____________________________________ **Date:** ___/___/___

Form received by external source (please indicate the location site i.e., nursing home) ____