HUDSON HEADWATERS
HEALTH NETWORK

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I understand and have been provided with a copy of Hudson Headwaters Health Network Privacy Practices that provides a more complete description of how the Network may use and disclose my protected health information in accordance with state and federal regulations for privacy and security. I further understand that Hudson Headwaters Health Network reserves the right to change its privacy practices. In the event of a change, a copy will be posted in a prominent location in the practice site, or upon my request, a copy will be sent to the address I have provided.

I, _____, date of birth _____, understand that as part of my health care, Hudson Headwaters Health Network originates and maintains paper and/or electronic records describing health history, symptoms, examination and test results, diagnoses, treatment, as well as plans for future care or treatment. I understand that this information serves as:

> A basis for planning my care and treatment.
> A means to facilitate coordination of care among the health professionals, including referrals, who contribute to my care.
> A source of information for applying my diagnosis and surgical information to my bill.
> A means by which a third-party payer can verify that services billed were actually provided.
> A tool for healthcare options of the Network such as assessing quality of care and reviewing competence of healthcare professionals.

I understand that Hudson Headwaters Health Network may send test results and correspondences associated with my care to the address I have provided. We may also leave messages at the telephone numbers I have provided either to confirm appointments or to request I call on medical, dental or billing items.

If you require a restriction on the above please see a staff member at the desk.

X_____ **X**_____

Patient's Signature or Signature of Patient Representative Date

☐ Patient refused to sign.

HUDSON HEADWATERS HEALTH NETWORK

RELEASE OF INFORMATION AND ASSIGNMENTS OF BENEFITS

I understand that my health information may be used or disclosed for the purposes of treatment, payment, and operations in accordance with state and federal regulations for privacy and security. I understand that this may include disclosures of information to my insurance carrier(s), including Medicare, private insurance, and any other health/medical plan, to issue payment directly to HHHN for medical services rendered to myself and/or my dependents. I am responsible for understanding the limitations of my insurance coverage and to present any co-pay (co- insurance, deductible) or other personal obligations at the time service is rendered. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

I give HHHN permission to disclose to a relative or friend my location and general condition, or other information directly relevant to that person's involvement in my care, to those I have named below: (please note: Certain medical conditions may require a separate release.)

_____

(please print first name, last name, and relationship)

Because Hudson Headwaters receives funding from the Federal Government we are required to collect information about income ranges. Please determine family size and check the appropriate income category box.

FAMILY SIZE	CATEGORY 1: ☐	CATEGORY 2: ☐	CATEGORY 3: ☐	CATEGORY 4: ☐
1	$0 - $11,769	$11,770 - $17,654	$17,655 - $23,539	$23,540 +
2	$0 - $15,929	$15,930 - $23,894	$23,895 - $31,859	$31,860 +
3	$0 - $20,089	$20,090 - $30,134	$30,135 - $40,179	$40,180 +
4	$0 - $24,249	$24,250 - $36,374	$36,375 - $48,499	$48,500 +
5	$0 - $28,409	$28,410 - $42,614	$42,615 - $56,819	$56,820 +
6	$0 - $32,569	$32,570 - $48,854	$48,855 - $65,139	$65,140 +
7	$0 - $36,729	$36,730 - $55,094	$55,095 - $73,459	$73,460 +
8	$0 - $40,889	$40,890 - $61,334	$61,335 - $81,779	$81,780 +
9	$0 - $45,049	$45,050 - $67,574	$67,575 - $90,099	$90,100 +
10	$0 - $49,209	$49,210 - $73,814	$73,815 - $98,419	$98,420 +

☐ Patient refused to answer.

X_____ **X**_____

Patient's Signature or Signature of Patient Representative

☐ Patient refused to sign.