HRC PROVIDER-PATIENT SERVICES AGREEMENT
Signature Page

I. ***(This must be signed prior to your first session.)***

I have received a copy of the HRC PROVIDER-PATIENT SERVICES AGREEMENT and a copy of the HRC PRIVACY NOTICE.

_____ _____
Name (Patient or Representative) Date

_____
Relationship

II. I have read, understand, and accept the following by **initialing** each item:

_____ that HRC may disclose Protected Health Information as necessary to my insurance company if I want my insurance to be filed. If this is not initialed, I understand that I must pay in full for services.

_____ that HRC may use Protected Health Information within the practice for the purpose of Treatment/Consultation

_____ that HRC may share Information as necessary with my primary care provider. If you do not wish information to be shared with your health care provider initial the "no" block below.

____ NO, do not share information with my physician

I would like to receive the following types of reminders about my appointments – **please initial all that apply**:

_____ Text messages about my appointments and office closures.

Mobile #:_____

_____ Email messages about my appointments and office closures.

Email Address:_____

_____ Voice messages about my appointments and office closures

The HRC office staff (circle one answer) is **ALLOWED** or **NOT ALLOWED** to contact my home number about appointments, billing issues, medications, question, etc.

I have read, understand, and accept all of the provisions of the HRC PROVIDER-PATIENT SERVICES AGREEMENT and the HRC PRIVACY NOTICE.

_____ _____
Signature (Patient or Representative) Date

_____ _____
Witness Date