



NOTICE OF NO SHOW POLICY ACKNOWLEDGEMENT

I understand that Bluegrass Pediatrics & Internal Medicine, PLLC has a NO SHOW policy. The policy is in effect to assist with the scheduling of patients. After three missed appointments **I** or **my child** may be dismissed from the practice.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessment and physician certifications.

I have received, read and understand Bluegrass Pediatrics & Internal Medicine PLLC, Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that Bluegrass Pediatrics & Internal Medicine PLLC restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand Bluegrass Pediatrics & Internal Medicine PLLC is not required to agree to my requested restriction but if Bluegrass Pediatrics & Internal Medicine PLLC does agree then Bluegrass Pediatrics & Internal Medicine is bound to abide by such restriction.

Specific Records Expressly Included. I expressly authorize release of the following information for the purposes of treatment, payment and healthcare operations, if it is part of my protected health information (**CHECK ANY OR ALL YOU AGREE TO AUTHORIZE FOR RELEASE**):

- Chemical Dependency/Substance Abuse
 - Drugs
 - Alcohol
- Sexually Transmitted Diseases

Signature of Patient or Personal Representative

Name of Patient or Personal Representative

Date

Description of Personal Representative's Authority