**SANTA YNEZ TRIBAL HEALTH CLINIC**

**US ARMY RESERVES / NATIONAL GUARD**

**Chart #: \_\_\_\_\_\_\_\_\_\_\_\_**

***Acknowledgment of Privacy Practices, Payment of Services & Health Care Directives***

I understand that the information provided by me is necessary for the US Army Reserves / National Guard personnel, in conjunction with the Santa Ynez Tribal Health Clinic (SYTHC) and staff, to provide services for my health and well-being. I understand that my health record information is securely stored either electronically or physically, and that my health record or any portion of my health record shall not be disclosed to another agency or person(s), unless specified as routine use, without my signed consent.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, acknowledge the following:

 (Print patient name or parent/legal guardian name here)

[ ]  I have been provided the *HIPAA Privacy Act Notice* to read.

[ ]  I have been provided the *Patient Rights and Responsibilities* *Notice* to read.

I may request a copy of either form from the receptionist if I so chose.

The Santa Ynez Tribal Health Clinic (SYTHC) is considered a training facility, and has, from time to time, non-employed staff (students, interns, interested physicians, health care representatives, surveyors, etc.) on our premises. Normally, these non-employed staff are allowed in patient care areas for observation and/or to assist a provider.

[ ]  I understand that I have the option, at any time, to request that non-employed staff (students, interns and/or other professionals) be excused while I am receiving direct patient care services.

**\_\_\_\_\_\_\_ Payment of Services:**

**(Initial Here)** I understand that I am financially responsible when:

* I require services beyond those covered by the US ARMY personnel;
* I falsely inform SYTHC that I do not have insurance to cover my services; and/or
* Any insurance I may have has been terminated.

**\_\_\_\_\_\_\_ Health Care Proxy/Advanced Health Care Directive:**

**(Initial Here)** If, at any time, I should become temporarily or permanently unable to make healthcare decisions, my healthcare proxy shall be: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

 (Print name here)

My healthcare proxy may make all decisions about:

* My Medical, Dental, and/or Behavioral (Mental) Health Care.

Such decisions shall be consistent with my wishes, or, if my wishes are unknown, shall be consistent with my best interest.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Print Name of Patient Date of Birth

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Place scan stamp here

Signature of Patient, Parent, Today’s Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian or Patient Representative

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature and Title of SYTHC Employee Today’s Date