AFFILIATES IN CLINICAL SERVICES, PC
305 Roseberry Street, Suite 8
Phillipsburg, NJ 08865-1600
(908) 454-7244 – Fax (908) 859-2109

PATIENT ACKNOWLEDGMENTS AND AUTHORIZATION

Print Patient's Full Name: _____

Date of Birth (mm/dd/yyyy): _____

Please ***initial*** each box and sign at the bottom of the page.

☐ I acknowledge receipt of *Patient Forms Checklist*, version 042612.

☐ I authorize Affiliates in Clinical Services (ACS) to evaluate and provide treatment as appropriate and I have legal responsibility to do so.

☐ I acknowledge receipt of the *HIPAA Privacy Notice*, version 042612 and agree to the contents.

☐ I acknowledge receipt of *Payment Contract for Services*, version 042612 and agree to the contents.

☐ I acknowledge receipt of *Provider-Patient Services Agreement Informed Consent*, version 042612 and agree to the contents.

☐ I acknowledge copy of any signed form will be considered as an original.

☐ I acknowledge the above and that I have had the opportunity to ask any questions considering ACS policies and practices.

☐ I acknowledge I will be charged a No Show/Late Cancelation Fee for appointments not canceled one business day in advance.

☐ I acknowledge standing appointments will be removed after three (3) missed appointments and will be rescheduled based on availability.

_____ _____
Printed name Relationship to patient

_____ _____
Signature Date

_____ _____
Form received by Date