canvas HEALTH

Client Acknowledgement Form Effective 2/21

Client ID: ____________
(for internal use only)

Client Name: ________________________________ **Date of Birth:** ____________________

_______ Init.

NOTICE OF PRIVACY PRACTICES

I affirm that I have been offered a copy of Canvas Health's *Notice of Privacy Practices*, and am aware that I may request a copy at any time, or view/download it on the Canvas Health website at www.canvashealth.org.

_______ Init.

INFORMED CONSENT TO TREATMENT

I affirm that I have been offered a copy of Canvas Health's *Informed Consent to Treatment* including fee information, and am aware that I may request a copy at any time, or view/download it on the Canvas Health website at www.canvashealth.org.

- Insurance Coverage; Appointment Cancellation/No Show Policy; Divorce/Custodial Situations; Sliding Fee Scale; Fee Responsibility

_______ Init.

APPOINTMENT CONFIRMATION *(please check all boxes that apply)*

I affirm that I have been offered a copy of Canvas Health's *Communication for Appointment Reminders*, and am aware that I may request a copy at any time, or view/download it on the Canvas Health website at www.canvashealth.org.

I agree to have Canvas Health: ☐ CALL and ☐ LEAVE MESSAGE for Appointment Reminders and Cancellations

☐ TEXT ☐ Email

Phone Numbers and or email which I authorize to receive appointment reminders:

____________________ ____________________ Name ________________________________

____________________ ____________________ Name ________________________________

Emergency Contact Information

☐ *In the event of an emergency, I authorize Canvas Health to contact the following individuals*

Full Name:	*Phone Number:*
Relationship to Client:	

Full Name:	*Phone Number:*
Relationship to Client:	

Receive Statements (*Send statement to another household although Client/Guardian is still responsible)*

Name:		*Relationship to Client:*
Street Address:		*Phone Number:*
City	*State:*	*Zip:*

_______ Init.

ASSIGNMENT and RELEASE

I, the undersigned, certify that I (or my dependent) have payer coverage and assign directly to Canvas Health all payer benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by payer. I hereby authorize Canvas Health to release all information necessary to secure the payment of benefits and to mail patient statements. I authorize the use of this signature on all payer submissions.

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Our Philosophy of Care includes being aware of how a person's mind and body affect how they are feeling. We consider it to be good care to coordinate between mental health providers and physical health providers who are treatment you. Please indicate your preference for this coordination of your care:

☐ I give permission for Canvas Health staff to contact my physician for the purpose of coordinating my care.
☐ I do not want my physician contacted.
☐ I have no physician that I am seeing.

Name of Clinic: ____

Name of Physician: ____

____ Client/Guardian Print (if client under 18)

_______________________________ Relationship to Client

____ Client/Guardian Signature (if client under 18)

_______________________________ Date