NOTICE OF PRIVACY PRACTICES,
RIGHTS & RESPONSIBILITIES and GRIEVANCE PROCEDURES RECEIPT
AND STATEMENTS OF UNDERSTANDING OF FINANCIAL ARRANGEMENTS

_____ I am in receipt of a program handbook that includes a copy of my rights and responsibilities as a person served by RIKC. I have also been informed of the grievance procedure.

_____ I am also in receipt of an outpatient orientation handbook and I have been advised that I can discuss my questions or concerns with my case manager.

_____ I am also in receipt of a copy of the Notice of Privacy Practices of RIKC that describes how my health information is used and shared.

_____ I have read these documents or have had them explained to me. I have had an opportunity to discuss these documents and I understand them as indicated by my signature. I understand I may ask the Patient Representative any questions I may still have and she/he will answer them to the best of their ability.

_____ I understand that I may receive billing statements from physicians who provide services to me while I am participating in my program. I understand that those billing statements are not generated by RIKC, and that if I have questions regarding those statements, I should contact that physician's billing service directly.

_____ I have received a copy of my insurance benefits information. Any questions I have regarding my financial arrangements and/or insurance coverage have been addressed. I understand that any further assistance or direction about my financial arrangements can be obtained from the Billing Office.

_____ ****I understand that any insurance benefits that have been explained to me by staff of RIKC were quoted by my insurance company and are <u>not</u> a guarantee of payment. I understand that it is my responsibility to review my insurance policy for benefits, co-pays, etc. and to call my insurance company if I have questions.**

_____ I agree to have information about my progress at RIKC released to the team of providers (doctors, therapists, case managers, etc.) who treated me at the referring facility.

_____ _____
Person Served or Legal Representative Date

_____ _____
Witness Date