



Nimkee

Memorial Wellness Center

2591 S. Leaton Rd.
Mt. Pleasant, MI 48858
Phone: 989.775.4600
Medical Fax: 989.775.4680
Dental Fax: 989.775.4957



Welcome to Nimkee Memorial Wellness Center (NMWC). We're glad you have chosen to register with us. Please fill out the registration forms completely to ensure we have all the necessary information to provide you with the best care possible. If you have any questions, our office is available at (989) 775 – 4670. For more information on our hours of operation, lab hours, Purchased Referred Care (PRC) information, on-call provider number, and other clinical information, please visit <http://www.sagchip.org/nimkee>. Thank you!

NMWC Business Office requires documentation to determine service eligibility. Patients, parents, guardians, pregnant persons, or eligible college students must submit the appropriate documentation below before services are rendered. You will be contacted once your eligibility has been determined; if you have not been notified within 24 – 48 business hours, please contact our office.

Eligible Service County Area(s): Isabella, Midland, Clare, Missaukee, & Arenac

1. Valid Tribal Membership Enrollment Card:
 - a. Saginaw Chippewa Indian Tribal enrollment ID
 - b. U.S federally recognized tribal enrollment ID (*residing in service area*) or verification letter
2. SCIT Direct Descendent:
 - a. Original birth certificate
 - b. Parent(s) SCIT Tribal enrollment ID
3. Social Security Card
4. All Insurance Card(s)
5. Two Residency Verification Documents: current physical address only
 - a. Driver's License;
 - b. State ID;
 - c. Voter Registration Card;
 - d. Lease Agreement;
 - e. Vehicle Title;
 - f. Envelope postmarked within the past 90 days. (*Including enrollees 's name*)
6. Newborn Children Only:
 - a. Hospital birth certificate
 - b. Parent(s) SCIT Tribal enrollment card
 - c. Original birth certificate once received to complete registration
7. Pregnant Person: Required in addition
 - a. Positive pregnancy test verification from OB/GYN
8. College Student: Required in addition
 - a. Official letter/official transcripts from institute verifying full-time student enrollment



1. Patient Information

(Last Name) (First Name) (MI)

_____/_____/_____
(Date of Birth) (Social Security Number) (Place of Birth)

(Physical Address) (City) (State) (Zip Code)

(Primary Phone) (Secondary Phone) (Work Phone) (E-Mail)

If Minor, child's parent/guardians name: _____

Gender: Female Male Transgender **Ethnicity:** Hispanic Non-Hispanic or Latin

Marital Status: Single Married Divorced Separated Widowed

Race:

- American Indian/Alaska Native
- Native Hawaiian/other Pacific Islander
- Black/African American
- White/Caucasian
- Asian
- Unknown

Preferred Language:

- English
- Spanish
- Other _____

Interpreter Needed: Yes No

Do you have an Advanced Directive? yes no

2. Tribal Affiliation

(Tribe of Membership) (Tribal Enrollment Number) (State where Enrolled)

3. U.S Veteran Status

Are you a U.S Veteran? Yes No

(Service Entry Date) (Service Separation Date) (Vietnam Service)

4. Employment Status

Are you employed? Yes No; Full-time Part-time Retired Student

(Occupation) (Employer Name)



5. Emergency Contact

_____	_____	_____	_____
(First Name)	(Last Name)	(Relationship)	(Phone Number)
_____	_____	_____	_____
(First Name)	(Last Name)	(Relationship)	(Phone Number)

6. Contact Preferences

How would you like NMWC to contact you about your appointments? Home Cell Email
 Would you like communication sent to you via email? (i.e., appointment reminders, updates, etc.) Yes No
 Do you have internet access? Yes No What access do you have? Internet Mobile

Insurance Information

PRIMARY INSURANCE

_____	_____
(SUBSCRIBER NAME)	(SUBSCRIBER ID #)
_____	_____
(SSN)	(DATE OF BIRTH)
_____	_____
(INSURANCE NAME)	(INSURANCE PHONE #)
_____	_____
(EFFECTIVE DATE)	(TERMINATION DATE)

COVERAGE TYPE:
 MEDICAL PHARMACY HOSPITAL DME DENTAL

ADDITIONAL POLICY MEMBERS & RELATIONSHIP

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Insurance Information

SECONDARY INSURANCE

_____	_____
(SUBSCRIBER NAME)	(SUBSCRIBER ID #)
_____	_____
(SSN)	(DATE OF BIRTH)
_____	_____
(INSURANCE NAME)	(INSURANCE PHONE #)
_____	_____
(EFFECTIVE DATE)	(TERMINATION DATE)

COVERAGE TYPE:
 MEDICAL PHARMACY HOSPITAL DME DENTAL

ADDITIONAL POLICY MEMBERS & RELATIONSHIP

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____





Insurance Billing Authorization

1. I authorize Nimkee Memorial Wellness Center of the Saginaw Chippewa Indian Tribe to bill my insurance carrier(s) for any and all services rendered by and through their facility.
2. I authorize my insurance carrier(s) to make direct payment to the Nimkee Memorial Wellness Center of the Saginaw Chippewa Indian Tribe for any and all services rendered by and through their facility. I also understand that I will not be billed for any services rendered at Nimkee Memorial Wellness Center except for Medical and dental labs.
3. I authorize Nimkee Memorial Wellness Center of the Saginaw Chippewa Indian Tribe to release any and all medical records concerning me to my insurance carrier(s) necessary to determine eligible benefits or the benefits payable for related services.
4. I have read and fully understand that this is a one-time signature authorization form for the Saginaw Chippewa Indian Tribe to authorize billing services to any and all of my insurance carrier(s), current and future.
5. I also understand that I will submit all new insurance information and cards in the event of a change, cancellation, addition, etc. I also understand that in the event of a name change, I will need to renew this form.
6. I have read and agree to the above paragraphs and authorize this implementation by my signature (if minor child) by parent/guardian signature.

Acknowledgment of Authorization

This authorization is to include carriers:

Medicare, Medicaid, Medigap, BC/BS, Railroad Retirement, and other insurance carriers not listed

(Patient Name)

(Patient Signature)

(Date)

(Minor Child Name)

(Parent or Guardian Signature)

(Date)

(NMWC Registration Staff Signature)

(Date)



Nimkee Memorial Wellness Center
Summary of Patient Rights & Responsibilities

PATIENT RIGHTS

- **The Right to Service Information.** Patients can access services from the hours of 8:00 a.m. – 5:00 p.m. Please call (989) 775-4600 regarding services available, after hours, and emergency care.
- **The Right to Accurate Information.** Patients are provided, to the degree known, information concerning their diagnosis, evaluation, treatment and prognosis. Patients are also entitled to have their patient information communicated to them in a clear language, or manner that is primarily used by the patient.
- **The Right to Choose.** Patients have the right to a choice of credentialed health care providers (and to know what credentials their provider holds). Patients also have the right to choose another provider (if another provider is available).
- **Being a Full Partner in Health Care Decisions.** Patients have the right to fully participate in all decisions related to their health care except when such participation is considered inadvisable. In this type of situation, patients who are unable to fully participate in treatment decisions have the right to be represented by parents, guardians, family members, or other conservators.
- **Care without Discrimination.** Patients have the right to be treated with dignity, consideration, and respectful care from all staff of the Nimkee Memorial Wellness Center (at all times and under all circumstances). Patients must not be discriminated against in the marketing, or enrollment, or in the provision of health care services, consistent with the benefits covered in their policy and/or as required by law.
- **The Right to Privacy.** Patients have the right to communicate with health care providers in confidence and to have the confidentiality of their individually-identifiable health care information protected. Patients also have the right to review and request a copy of their own medical records and request amendments to their records.
- **The Right to Disclosure.** Patient disclosures and records are treated confidentially. Patients are given the opportunity to approve or refuse their release, except when the release is required by law.
- **The Right to Speedy Complaint Resolution.** Patients have the right to file grievances, in writing, regarding his/her care in accordance with the Patient Complaint/Grievance Policy. Nimkee Memorial Wellness Center activities and providers are covered through the Federal Torts Claims Act.
- **Right to an Advance Directive (Living Will, Durable Power of Attorney).** Patients have a right to obtain and have an advance directive for health care decisions; to have your advance directive (if you have one) included in your medical record; and to have your directive followed to the extent medically appropriate and lawful.

PATIENT RESPONSIBILITIES

- **Appointments.** Please keep all scheduled appointments. If unable to keep the scheduled appointment, notification to the appropriate department is needed at least 24 hours in advance (unless there is as documented emergency).
- **Taking on New Responsibilities -** In a health care system that affords patient rights and protections, you as our patient, must also take greater responsibility for maintaining good health:
- **Late or Missed Appointments.** If you might be late to an appointment, it is important to call as we may not be able to guarantee you will be seen. You may need to be rescheduled for a different time and/or day.
- **Patient Conduct.** Please cooperate with all persons providing your care and treatment, and respect the property, environment and privacy of other patients.
- **Provision of Information.** It is important to provide accurate and complete information regarding your health problems and medical history by answering all questions as truthfully and completely as you can. Also, to inform the health care provider of any medications, including over-the-counter products, dietary supplements, and any allergies or sensitivities.
- **Ask Questions and Follow Instructions.** Please try to understand and follow instructions concerning your treatment and ask questions if you do not understand or need an explanation.
- **Transportation.** Please provide a responsible adult to transport him/her home from the Clinic and remain with him/her for twenty-four (24) hours, if required by his/her provider.
- **Medical Provisions.** It is important to inform your provider about any living will, medical power of attorney, or other directive that could affect your care.
- **Medical Center Charges.** Please be responsible providing payment for treatment and to be cooperative and timely in providing insurance information.
- **Refusal of Treatment/Accepting Consequences.** Please be aware of your responsibility for consequences following a decision to refuse treatment or instructions.
- **Contact Information.** Please provide an accurate contact phone number and address information at each visit.

(Patient Name)

(Patient Signature)

(Date)





Patient Health Assessment

Patient Name: _____ **Date of Birth:** _____

Parent/Guardian Name: _____ **Today's Date:** _____

Parent/Guardian Phone Number: _____

Have you been seen by another provider? No Yes

If yes, complete the Authorization for Use or Disclosure of Protected Health Information Form
(You must sign the authorization with a Nimkee Staff as a witness.)

Have you ever been hospitalized or had a major operation?

No Yes, please specify: _____

Are you allergic to any of the following? Aspirin Penicillin Codeine Acrylic Latex

List all other food, drugs, and substances to which you are allergic:

List any prescription medications you take:

Do you have any other medical concerns you would like us to know about?:

Surgical History

Surgery:	Yes	No	Comments / Details / Dates
Transfusions(s)			
Adverse Reaction to Anesthesia			
Easy Bruising Tendancy			
Easy Bleeding			
AAA Repair			
Appendectomy			
Cholecystectomy (Gallbladder Removal)			
Colostomy			
Hernia Repair (Femoral/Incisional/Inguinal)			

Surgical History Continued

Surgery:	Yes	No	Comments / Details / Dates
Pancreatectomy			
Repair of Abdominal Wall			
Small Bowel Resection			
Splenectomy			
Surgical Treatment for Ulcer			
Tonsillectomy			
Previous CABG			
Lung Surgery			
Thyroid Surgery			
Orthopedic Surgery			
Implant/Metal Placement/Artificial Joint			
Other Surger Not Listed			
Breast Reconstruction			
Cesarean Section Delivery			
Hysterectomy (Total/Partial)			
Tubal Ligation			

Self Medical History

Have you had or currently have any of the following?	Yes	No	Comments / Details / Dates
Reaction to Anesthetics			
Myocardial Infarction/Heart Attack			
Alzheimer Disease			
Sickle Cell Anemia			
Bleeds Easily			
Breast Cancer			
Ovarian Cancer			
Colon Cancer			
Other Cancer			
Coronary Artery Disease			
Diabetes Mellitus			
Glaucoma			
Hepatic Disorder(s)			
Hepatitis A Virus			
Hepatitis B Virus			
Hepatitis C Virus			
Jaundice			
HIV Infection			
Hypertension/High Blood Pressure			
Migraine Headache			
Osteoarthritis			
Osteoporosis			
Pancreatitis			
Psychiatric Disorder(s)			
Asthma			
Tuberculosis			
Epilepsy and/or Recurrent Seizures			

Self Medical History Continued

Have you had or currently have any of the following?	Yes	No	Comments / Details / Dates
Stroke Syndrome			
Drug Abuse			
Thyroid Disorder(s)			
Other Self Medical Health History			

Social History

Substance Use:	Yes	No	Type / Amount Each Use / How Often
Alcohol Use			
Tobacco			
Previous History of Smoking			
Drug Use			
Caffeine Use			
Relational History:	Yes	No	Comments / Details / Dates
Married and Living with Spouse			
Divorced			
Single			
Living Conditions:	Yes	No	Comments / Details / Dates
Living with Parents			
Caretaker of Another Person			
Resides in ALF			
Living Alone			
Other			
Other Social:	Yes	No	Comments / Details / Dates
Occupation			
Retired			
Student			
Recent Travel (within the last 6 months)			

Gynecological (Women Only)

Last Pap Smear: _____
MM/DD/YYYY

First Day of Last Menstruation: _____
MM/DD/YYYY

Previous Pregnancies Gravida: _____
(Total Number)

Total Vaginal Delivery: _____

Previous Pregnancies Para: _____
(Total Deliveries)

Total Cesarean Delivery: _____

Previous Pregnancies Aborta: _____
(Total Losses, Including Miscarraiges)

Currently Breastfeeding? Yes No

Age of Menopause: _____

Breast Issues? Yes No

Hysterectomy(Total/Partial): _____

Any Abnormal Bleeding? Yes No

Contraception: _____



Permission to Treat a Minor without a Parent / Legal Guardian Present

Please be advised that Nimkee Memorial Wellness Center requires parental or legal guardian consent before providing treatment for any non-life-threatening injuries or illnesses. To ensure that your child can receive prompt medical attention, we request that you complete this form, which grants us permission to treat your child if you are unable to accompany them to the clinic. Thank you for your cooperation in ensuring the safety and well-being of your child.

Please Note:

- A parent/legal guardian **MUST** be present for their child's first visit at Nimkee Memorial Wellness Center, Medical and Dental Clinics.
- Minors may not receive immunizations without a parent or guardian present.
- A minor must be at least 16 years of age to receive certain types of treatment in the Medical / Dental Clinic without a parent/legal guardian being present and must bring in a completed "Permission to Treat a Minor" form.
- In certain circumstances, in accordance with Tribal, State, and Federal laws, parent/guardian permission may not be needed for adolescents being seen for concerns of "heightened sensitivity" such as family planning, testing, counseling, and treatment for STI's.

Patient name: _____ Health Record Number: _____

Date of Birth: _____ Today's date: _____

I hereby authorize _____ (an adult into whose care the minor has been entrusted) to arrange for and authorize routine and emergency treatment at Nimkee Memorial Wellness Center.

[] Please initial here if you are authorizing a minor to seek and consent to treatment without an adult present. This consent applies to certain care, treatment, and procedures defined in the Nimkee Memorial Wellness Center policy for Medical / Dental Care of Minors.

In case of emergency, I can be reached at:

Primary phone: _____ Secondary phone: _____

Work phone: _____ Other: _____

Signature: _____ Date: _____
Parent/Legal Guardian

Printed Name: _____ Relationship to patient: _____

[] Check here if you would like the authorization to be valid for 1 year

[] Check here if you would like the authorization to be valid ONLY for the date of the appointment



Notice of Privacy Practices

"THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY."

Effective date: April 14, 2003

I. Understanding Your Health Record/Information

Each time you visit Nimkee Memorial Wellness Center for services, a record of your visit is made. Typically, this record contains your symptoms, examination, test results, diagnoses, treatment, and a plan for future care. This information, often referred to as your health record, serves as a:

- Plan for your care and treatment. Communication source between the health care professionals.
- Tool with which we can check results and continually work to improve the care we provide.
- Means by which Medicare, Medicaid or private insurance payers can verify the services billed.
- Tool for education of health care professionals.
- Source of information for public health authorities charged with improving the health of the people.
- Potential source of data for medical research, facility planning and marketing (your name or identity would not be used).
- Legal document that describes the care you receive.

Understanding what is in your health record and how the information is used helps you to:

- Ensure its accuracy
- Better understand why others may review your health information
- Make an informed decision when authorizing disclosures

II. Your Health Information Rights

Although your health record is the physical property of the Nimkee Memorial Wellness Center, the information belongs to you.

You have the right to:

- **Inspect and receive a copy your health record**
- **Request a restriction** on certain uses and disclosures of your health information. For example, you could ask that we not disclose the treatment you had to a family member. Nimkee is not required to agree to your request; but if we do, we will comply with your request unless the information is needed to provide you with emergency services.
- **Request a correction/amendment to your health record** if you believe the health information we have about you is incorrect or incomplete.
- **Request confidential communications about your health information.** You can ask that we communicate with you at a location of your choice, e.g., you can ask that we contact you at work instead of at home or vice versa.
- **Receive a listing of the disclosures Nimkee has made** of your health information upon request. This information is maintained for six years.
- **Revoke your written authorization to use or disclose health information.** This does not apply to health information already disclosed or used.
- **Obtain a paper copy of the Nimkee Notice of Privacy Practices** upon request.

III. Nimkee Responsibilities

The Nimkee Memorial Wellness Center is required by law to:

- Maintain the privacy of your health information
- Inform you about our privacy practices regarding health information we collect and maintain about you
- Notify you if we are unable to agree to a requested restriction
-



Notice of Privacy Practices

- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations
- Honor terms of this notice

Nimkee reserves the right to change its privacy practices and to make the new provisions effective for all protected health information it maintains. Nimkee will post any revised Notice of Privacy Practices in the reception areas and other public places of Nimkee as soon as possible after the revision. You may request a copy of the notice.

Nimkee understands that health information about you is personal and is committed to protecting your health information. **Nimkee will not use or disclose your health information without your permission, except as described in this notice and as permitted by the Privacy Act.**

IV. How Nimkee may use and disclose health information about you.

The following categories describe how we may use and disclose health information about you.

A. We will use your health information to provide your treatment.

For example: Your personal information will be recorded in your health record and used to determine the course of treatment for you. Your health care provider will document in your health record her/his instructions to members of your healthcare team. The actions taken and the observations made by the members of your healthcare team will be recorded in your health record so your health care provider will know how you are responding to treatment.

If Nimkee refers you to another health care facility or health care provider, Nimkee will exchange your health information with that health care provider for treatment decisions.

If you are transferred to another facility for further care and treatment, Nimkee will exchange information with that facility to enable them to know the extent of treatment you have received.

Your health care provider(s) may give copies of your health information to others to assist in your treatment.

B. We will use your health information for payment.

For example: If you have private insurance, Medicare, or Medicaid, a bill will be sent to your health plan for payment. The information on or accompanying the bill will include information that identifies you, as well as your diagnosis, procedures, and supplies used for your treatment.

If Nimkee sends you to another health care facility using Purchased Referred Care (PRC), Nimkee will exchange your health information with that provider for health care payment decisions.

C. We will use your health information for health care operations.

For example: We may use your health information to evaluate your care and outcomes. This information will be used to continually improve the quality and effectiveness of the services we provide. This includes health care services provided under Purchased Referred Care (PRC).

- **Business Associates:** Nimkee provides some healthcare services through contracts with business associates. Examples include: emergency room physicians, podiatry medicine, radiology, and laboratory tests. When these services are contracted, Nimkee may release your health information to business associates so that they can perform their job. We require our business associates to safeguard your health information.
- **Notification:** Nimkee may use or disclose information to notify a family member or personal representative about your care in an emergency situation.
- **Communication with Family or personal representative:** Nimkee health providers may disclose your health information to others as directed by you. For example, Nimkee may inform your family members, relatives, close personal friends or any other person you identify. This disclosure of health information is relevant to that person's involvement in providing care or payment for services.
- **Interpreters:** In order to provide you proper care and services, Nimkee may use the services of an interpreter. This may involve disclosing your personal health information.
- **Research:** Nimkee may disclose information for research purposes that has been approved by an Tribal Health Board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.
- **Funeral Directors:** Nimkee may disclose health information to funeral directors as required by law to carry out their duties.
- **Organ Procurement Organizations:** Consistent with applicable laws, Nimkee may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.
- **Health Promotion:** Nimkee may contact you to provide information about other types of health-related benefits and services that may be of interest to you. Example: We may contact you about the availability of new services for diabetes.
- **Appointment Reminders:** Nimkee, for example, may contact you with a reminder that you have an appointment for medical care at our facilities.



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- **Treatment Alternatives:** Nimkee may recommend possible treatment alternatives and options that may be of interest to you, using your health information. Example: We may refer for acupuncture.
- **Food and Drug Administration (FDA):** Nimkee may disclose to the FDA your health information, if you have experienced adverse events with food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.
- **Workers Compensation:** Nimkee will disclose health information to workers compensation as required by law.
- **Public Health:** Nimkee will disclose, as required by law, your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability, charged with receiving reports of child abuse or neglect, and charged with receiving information of abuse, neglect, or domestic violence. Nimkee may disclose your health information to an individual who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition.
- **Correctional Institution:** Should you be an inmate of a correctional institution, Nimkee may disclose to the institution, health information necessary for your health and the health and safety of other individuals.
- **Law Enforcement:** Nimkee may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena or court order.
- **Members of the Military:** If you are a member of the military services or U.S. Public Health Service Commissioned Corps, Nimkee may disclose your health information to your military command authorities.
- **Health Oversight Authorities:** Nimkee may disclose health information to health oversight authorities for activities authorized by law. These oversight activities include: investigations, audits, inspections and other actions. These are necessary for the government to monitor the health care system, government programs, and monitor compliance with civil rights laws.

Federal law makes provision for your health information to be disclosed to an appropriate health oversight agency, public health authority or attorney. This health information may be disclosed, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

- **Non Violation of this Notice:** Nimkee is not in violation of this Notice or the HIPAA Privacy Rule if any of its employees, business associates or contractors discloses information under the following circumstances:
- **Disclosures by Whistleblowers:** If an Nimkee employee, business associate or contractor in its judgment and in good faith believes that Nimkee has violated or is violating clinical and professional standards that has the potential of endangering patients or members of the public and discloses such information to:
 - a. Public Health Authority, Health Oversight Authority, accrediting agencies or any other agency for the purpose of investigating the violation or complaints.
 - b. To an attorney on behalf of the workforce member, business associate or contractor or hired by the workforce member, business associate or contractor for the purpose of determining their legal options regarding the suspected violation.
- **Disclosures by Workforce Member Crime Victims:** A Nimkee employee who is a victim of a crime on or off the clinic premises may disclose information about the suspect to law enforcement official provided that:
 - a. The information disclosed is about the suspect who committed the criminal act.
 - b. The information disclosed is limited to identifying and locating the suspect.

Any other uses and disclosures will be made only with your written authorization, which you may later revoke in writing at any time.

To exercise your rights under this Notice, to ask for more information, or to report a problem

You must contact the Nimkee HIPAA Coordinator in writing at:

**C/O HIPAA Coordinator
Nimkee Memorial Wellness Center
2591 South Leaton Road
Mt. Pleasant, MI 48858**

If you believe your privacy rights have been violated, you may file a written complaint with the above individual or the Secretary of Health and Human Services, U.S. Department of Health and Human Services, Washington, D.C. 20201. There will be no retaliation for filing a complaint.

Effective Date: April 14, 2003



**Acknowledgment of Receipt of
Nimkee Memorial Wellness Center
Notice of Privacy Practices**

I hereby acknowledge receipt of the Nimkee Memorial Wellness Center Notice of Privacy Practices at:

**Nimkee Memorial Wellness Center
2591 South Leaton
Mt. Pleasant, MI 48858**

(Print Patient Name)

(Patient Signature)

(Date)

(NMWC Registration Staff Signature)

(Date)

For Patients Unable to Acknowledge Receipt

I hereby certify that the patient was unable to acknowledge receipt of the Nimkee Notice of Practices because:

(NMWC Registration Staff Signature)

(Date)

