Mercy Clinics, Inc.
A member of Mercy Medical Center-Des Moines

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

_____ (insert individual name) acknowledge that I received a copy of Mercy Medical Center Notice of Privacy Practices dated __11/2014__ (Insert date of Notice of Privacy Practices).

_____
(Individual's signature or initials)

(Personal representative of individual, if individual is unable to sign)

_____
(Date)

_____
(Witness signature)

Individual (or personal representative of the individual) did not sign the acknowledgement for the following reason:

(check (√) _ one of the reasons below)

- ❑ Individual refused
- ❑ Individual refused, stating that he/she has already signed an acknowledgement
- ❑ Individual unable to sign because of medical condition
- ❑ There was not a personal representative of the individual available to sign
- ❑ Other (explain) _____
  _____
  _____

_____ _____
Witness Date

1019-102-W 9/20/13

Iowa Diabetes and Endocrinology Center

Research Information

Our clinic is excited to offer our patients the chance to take part in clinical research trials. By signing below, I allow the clinic to screen my record for research trials. I understand that I still have the right to refuse participation in any trial that is offered to me.

- ☐ Yes, please screen my chart for research studies.
- ☐ No, do not screen my chart for research studies.

Cancellation Policy

We understand there are many circumstances which may require cancelling or missing your appointment. There are many patients on our waiting list. Calling to cancel your appointment will allow us to make this appointment time available to others. Failure to call and cancel an appointment repeatedly may result in suspension from the clinic.

Printed Name: _____ Date of Birth: _____

Signature: _____ Today's Date: _____

(Patient or Authorized Person)