Square Medical Group

124 Watertown Street, Suite 2D
Watertown, MA 02472

884 Washington St, Floor 2
Weymouth, MA 02189

Acknowledgement of Consent and Acceptance of Materials

By signing this form, I acknowledge that I have received, reviewed and understand the following materials and I consent to treatment at Square Medical Group.

Please check the box next to each applicable document.

You are entitled to request copies of anything in this packet for your records. You also have an ongoing opportunity to ask questions regarding their content:

For All Intakes

- ☐ Cancellation Policy
- ☐ H.I.P.A.A. Policy
- ☐ Admission and Admission Exclusion Criteria
- ☐ Notice of Patient Rights
- ☐ Discharge Policy
- ☐ Grievance Procedure
- ☐ Approach to Billing and Self-Pay Rates
- ☐ Notice of Privacy Practices
- ☐ Acknowledgement of Consent and Acceptance of Materials (this document)

____
Patient Name (Please Print)

X ______________________________________ ________________
Patient Signature Date

X ______________________________________ ________________
Patient Representative’s Signature (if applicable) Date

Follow- Up Policy:

I Agree ☐, do not Agree ☐ to be contacted for clinical follow-up by Square Medical Group within 60 days of discharge.

If I do agree, then by what mode of communication do you prefer?

☐ Phone ☐ E-Mail ☐ US Mail