Policies

Parris and Associates Office Policies

Office hours are from **9:00am to 5:00pm Monday - Thursday** and **9:00am to 12:00pm on Friday**. We Are closed for **lunch between 12:00pm and 1:00pm daily. Saturday is by appointment only.** Please call 911 for all emergencies.

Please check the box next to each line to signify understanding and acknowledgment of these policies.

- [ ] While our physicians strive to remain on schedule, there may be times when they fall behind due to emergencies or unforseen circumstances. We understand if you cannot wait to to be seen. The front desk will be happy to assist in rescheduling your appointment if you desire.

- [ ] You will be reminded of your appointment 48-72 hours before your appointment. If you are unable to keep your scheduled appointment, please give us at least 24 hours before your appointment. If you fail to do so, Parris and Associates reserves the right to charge a fee for no shows and improper cancellations. The fee is $50 for a new patient, $25 for an established patient appointment, and $75 for an infusion visit..

- [ ] If you are 15 minutes late for your appointment, you may be asked to reschedule. If you have incurred three (3) documented "no-shows" and "same-day cancellations", you may be subject to dismissal from the practice. Your chart is reviewed, and dismissals are determined by a physician only.

- [ ] It is the patient's responsibility to provide Parris and Associates with accurate and current insurance information, ready to present insurance card(s) and photo ID at each visit.

- [ ] It is the patient's responsibility to check with their insurance to make sure our providers are in network. The patient must also contact their insurance with any questions or concerns regarding cost/coverage of all services including but not limited to office visits, bloodwork, and radiology services.

- [ ] Copays are collected at the time of the visit during check-in as well as payment towards meeting deductibles and any outstanding balance.

- [ ] If your account becomes delinquent, it will be placed with a collection agency. The patient is responsible for reasonable collection costs including attorney fees.

- [ ] Parris and Associates requires patients to contact us during office hours with any prescription requests. We ask that you do not come to the office regarding refills without an appointment out of respect for our other patients being seen by nurses and doctors. Please call at least 48 hours before your prescription runs out. Narcotic prescriptions are written at the discretion of the providers and will only be filled at scheduled appointments and may require urine testing.

- [ ] Bloodwork results take at least 7-14 days to come back to our office and be reviewed by the provider. Please review your results on the patient portal at web.gobreeze.com

- [ ] Disability, disabled parking affidavits, and FMLA paperwork are sometimes requested by our patients. You must be a part of the practice for at least 1.5 years or have had at least 6 visits. After meeting those requirements, paperwork requested by the patient may be filled out at the discretion of our providers. There is no guarantee that the provider will approve your request regardless of status with our practice. Paperwork may require a referral or a functional capacity evaluation. A separate appointment is required to complete the necessary information to fill out paperwork. We do not see worker's compensation cases.

- [ ] Parris and Associates charges a service fee for paperwork of $150 for 1-3 pages, $250 for 4-6 pages, and $350 for 7-10 pages. Disability parking affidavits are $20. Parris and Associates may require a new referral sent from the referring physician, send note to referring doctor of no show we will only schedule one time.NSF fee of $50 will be charged to your account in the event your check does not clear your bank.

PATIENT/GUARDIAN SIGNATURE

Referring Physician

REFERRING PHYSICIAN:

REFERRING PHYSICIAN ADDRESS:

REFERRING PHYSICIAN #:

Health Assessment Questionnaire

Patient Name: $(patient.name)

The following questions will help determine if you have had any recent infections.

Please take a few minutes to answer the following questions.

In the past two (2) weeks have you had any of the following symptoms?

NIGHT SWEATS

YES NO

SORE THROAT

YES NO

RUNNY NOSE

YES NO

FACE PAIN

YES NO

EAR ACHE

YES NO

TOOTH PAIN

YES NO

COUGH

YES NO

BREATHING PROBLEM

YES NO

PAINFUL URINATION

YES NO

BLOODY URINE

YES NO

ANTIBIOTIC USE

YES NO

HEADACHE

YES NO

WOUND COMPLICATION

YES NO

In the past two (2) weeks have you had any of the following?

SURGERY

YES NO

SURGERY COMPLICATIONS

YES NO

INCISIONAL DRAINAGE

YES NO

TUBERCULOSIS

YES NO

CHEST X-RAY

YES NO

HEPATITIS

YES NO

PREVIOUS TRANSFUSION

YES NO

VACCINATIONS

YES NO

LIST ALLERGIES

Primary Care Physician

PRIMARY CARE PHYSICIAN:

PRIMARY CARE PHYSICIAN ADDRESS:

PRIMARY CARE PHYSICIAN #:

PRE INFUSION CHECK LIST

Pre-Infusion Questionnaire

Please answer the questions listed below as a Yes/No:

HAVE ANY KIND OF INFECTION, EVEN IF IT IS SMALL (SUCH AS AN OPEN CUT OR SORE), OR THE FLU

YES NO

HAVE AN INFECTION THAT WILL NOT GO AWAY OR AN INFECTION THAT KEEPS COMING BACK

YES NO

HAVE HAD ALLERGIC REACTION TO THIS INFUSION IN THE PAST

YES NO

HAVE OR HAD INFLAMMATION OF YOUR LIVER DUE TO AN INFECTION (VIRAL HEPATITIS)

YES NO

HAVE HAD A LUNG INFECTION CALLED TUBERCULOSIS (TB), A POSITIVE SKIN TEST FOR TB OR A BLOOD TEST, ARE IN CLOSE CONTACT WITH SOMEONE WHO HAS HAD TB

YES NO

HAVE COUGH THAT DOES NOT GO AWAY

YES NO

ARE PREGNANT OR PLAN TO BECOME PREGNANT

YES NO

ARE BREASTFEEDING OR PLAN TO BREASTFEED

YES NO

HAVE WEIGHT LOSS

YES NO

Privacy and Billing Consent Form

This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your health care information.

Consent Related to Privacy Notice:

I have had a chance to review the Practice Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.

Consent for Care:

I, $(patient.name) with my signature, authorize (this practice), and any employee working under the direction of the physician, to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but not limited to) preventative, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body and the sale or dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professionals for care and treatment.

Consent for Release of Information and Assignment of Benefits:

I also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities. I consent to assign all payments for services directly to this practice. I further consent to the use for any practice operational needs as identified in the Practice Privacy Notice.

Financial Policy:

We appreciate you choosing us for your healthcare. We will adhere to the following financial policy in order to consistently deliver high quality care and services. The patient/responsible party assumes responsibility to ensure that the financial obligation is fulfilled for the health care services received.

- I understand that I am responsible for all co-payments, amounts applied to deductibles, co-insurance, and other amounts that may be deemed my responsibility by the payment sources, as required by my contract with my insurance plan and state regulations.
- I understand that if I have an insurance co-payment, I am expected to make payment when checking in for my appointment.
- I understand that my contract with my insurance entity may or may not cover some services. All insurance policies are not the same. They vary by employer group. $(practice.name) is not responsible or able to know every policy available. It is my responsibility to verify applicable coverage prior to receiving the services. For example, not all health plans include screenings as a benefit. If I seek care outside of the contract terms, I am aware that I may be responsible for all charges that are incurred.

Thank you for your understanding and cooperation with this policy. It is our privilege to provide your medical care.

I have read and understand the Consents and Financial Policy stated above and agree to accept full responsibility as described above.

PATIENT/RESPONSIBLE PARTY

Pharmacy

PHARMACY:

PHARMACY ADDRESS

PHARMACY #:

Patient Consent

$(patient.name) hereby states that by signing this Consent I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out is health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. I understand that, and consent to, the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.

4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.

5. I understand that I have a right to request that the Practice restrict how my **PHI** is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.

7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

8.I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

SIGNATURE OF PATIENT

Privacy and Billing Consent Form

This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your health care information.

Consent Related to Privacy Notice:

I $(patient.name) have had a chance to review the Practice Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.

Consent for Care:

I, $(patient.name) with my signature, authorize (this practice), and any employee working under the direction of the physician, to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but not limited to) preventative, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body and the sale or dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professionals for care and treatment.

Consent for Release of Information and Assignment of Benefits:

I also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities. I consent to assign all payments for services directly to this practice. I further consent to the use for any practice operational needs as identified in the Practice Privacy Notice.

Financial Policy:

We appreciate you choosing us for your healthcare. We will adhere to the following financial policy in order to consistently deliver high quality care and services. The patient/responsible party assumes responsibility to ensure that the financial obligation is fulfilled for the health care services received.

- I understand that I am responsible for all co-payments, amounts applied to deductibles, co-insurance, and other amounts that may be deemed my responsibility by the payment sources, as required by my contract with my insurance plan and state regulations.
- I understand that if I have an insurance co-payment, I am expected to make payment when checking in for my appointment.
- I understand that my contract with my insurance entity may or may not cover some services. All insurance policies are not the same. They vary by employer group. $(practice.name) is not responsible or able to know every policy available. It is my responsibility to verify applicable coverage prior to receiving the services. For example, not all health plans include screenings as a benefit. If I seek care outside of the contract terms, I am aware that I may be responsible for all charges that are incurred.

Thank you for your understanding and cooperation with this policy. It is our privilege to provide your medical care.

I have read and understand the Consents and Financial Policy stated above and agree to accept full responsibility as described above.

PATIENT/RESPONSIBLE PARTY

HIPAA 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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

TABLE OF CONTENTS

A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart [and on a computer][and in an electronic health record/personal health record]. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1.Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.

2.Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3.Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts.

4.[Optional]: Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5.Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6.Notification and Communication With Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7.Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8.Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

9.Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

10.Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

11.Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.

12.Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

13.Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

14.Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

15.Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

16.Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

17.Proof of Immunization. We will disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or your dependent.

18.Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

19.Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

20.Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

21.Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate. [Note: Only use e-mail notification if you are certain it will not contain PHI and it will not disclose inappropriate information. For example, if your e- mail address is "digestivediseaseassociates.com" an e-mail sent with this address could, if intercepted, identify the patient and their condition.]

(Add the following three activities, or any of the three, if the organization engages or intends to engage in these activities.)

22.Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

B. When This Medical Practice May Not Use, or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. [*For practices with websites add:* We will also post the current notice on our website.)

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

[insert name and contact information for the local DHHS Office of Civil Rights]

OCRMail@hhs.gov (mailto:OCRMail@hhs.gov)

The complaint form may be found at (http://www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf)**www.hhs.gov/ocr/privacy/hipaa/complaints/hipcompla... (http://www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf)**.

You will not be penalized in any way for filing a complaint.

PATIENT/GUARDIAN SIGNATURE

Patient Communication Form

From time to time in caring for our patients it may become necessary to contact you. Often our patients are not available when we all them and we would like to be able to leave detailed telephone messages (i.e. lab results) when possible. There are also times where you may want us to communicate labs, medications, treatment plans, or billing information to a trusted family member or friend. In order to protect your privacy we need your written permission to leave detailed messages on your answering machine, voicemail or with a trusted family member or friend.

☐ I DO CONSENT

I $(patient.name) consent for my healthcare provider to leave detailed message regarding my personal health information (PHI) using the following options: (Provide information below) **Please note this consent will remain in effect until you rescind in writing.**

HOME PHONE NUMBER

(___) ___-____

MY CELL PHONE NUMBER

(___) ___-____

MY WORK PHONE NUMBER

(___) ___-____

NAME OF FAMILY OR FRIEND AND PHONE NUMBER

Please state relationship to patient

NAME OF FAMILY OR FRIEND AND PHONE NUMBER

Please state relationship to patient

I DO NOT CONSENT

☐ For my provider to leave detailed telephone messages regarding my personal health information (PHI)

☐ For my provider to communicate messages regarding my personal health information (PHI) to family members.

REVOCATION OF PRIOR CONSENT

☐ I wish to rescind or stop any prior consent to leave detailed messages.

☐ I wish to rescind or stop any prior consent for my provider to communicate messages regarding my personal health information (PHI) to family members.

PATIENT AND/OR PATIENT'S REPRESENTATIVE SIGNATURE

HIPAA 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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

TABLE OF CONTENTS

A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart [and on a computer][and in an electronic health record/personal health record]. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1.Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.

2.Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3.Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. [Participants in organized health care arrangements only should add: We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.]

4.[Optional]: Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5.Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6.Notification and Communication With Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7.Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8.Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

9.Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

10.Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

11.Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.

12.Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

13.Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

14.Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

15.Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

16.Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

17.Proof of Immunization. We will disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or your dependent.

18.Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

19.Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

20.Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

21.Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate. [Note: Only use e-mail notification if you are certain it will not contain PHI and it will not disclose inappropriate information. For example, if your e- mail address is "digestivediseaseassociates.com" an e-mail sent with this address could, if intercepted, identify the patient and their condition.]

(Add the following three activities, or any of the three, if the organization engages or intends to engage in these activities.)

22.Psychotherapy Notes. We will not use or disclose your psychotherapy notes without your prior written authorization except for the following:

1. Use by the originator of the notes for your treatment
2. For training our staff, students and other trainees
3. To defend ourselves if you sue us or bring some other legal proceeding
4. If the law requires us to disclose the information to you or the Secretary of HHS or for some other reason
5. In response to health oversight activities concerning your psychotherapist
6. To avert a serious and imminent threat to health or safety
7. To the coroner or medical examiner after you die. To the extent, you revoke an authorization to use or disclose your psychotherapy notes, we will stop using or disclosing these notes.

23.Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

24.Fundraising. We may use or disclose your demographic information in order to contact you for our fundraising activities. For example, we may use the dates that you received treatment, the department of service, your treating physician, outcome information and health insurance status to identify individuals that may be interested in participating in fundraising activities. If you do not want to receive these materials, notify the Privacy Officer listed at the top of this Notice of Privacy Practices and we will stop any further fundraising communications. Similarly, you should notify the Privacy Officer if you decide you want to start receiving these solicitations again.

B. When This Medical Practice May Not Use, or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1.Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2.Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3.Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4.Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5.Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6.Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. [*For practices with websites add:* We will also post the current notice on our website.)

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

[insert name and contact information for the local DHHS Office of Civil Rights]

OCRMail@hhs.gov (mailto:OCRMail@hhs.gov)

The complaint form may be found at (http://www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf)**www.hhs.gov/ocr/privacy/hipaa/complaints/hipcompla... (http://www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf)**.

You will not be penalized in any way for filing a complaint.

Patient Communication Form

From time to time in caring for our patients it may become necessary to contact you by telephone. Often our patients are not available when we call them and we would like to be able to leave detailed telephone messages (i.e. lab results) when possible. There are also times where you may want us to communicate labs, medication, treatment plans, or billing information to a trusted family member. In order to protect your privacy we need your written permission to leave detailed telephone messages on your answering machine, voice mail system, or with a trusted family member.

PATIENT NAME

PATIENT'S DATE OF BIRTH:

MM / DD / YYYY

☐ I DO CONSENT

for my healthcare provider to leave detailed telephone messages regarding my personal health information (PHI) using the following options: (Provide the information below and initial each one that you want us to use for messages).

HOME PHONE NUMBER:

MY CELL PHONE NUMBER:

MY WORK PHONE NUMBER:

SPOUSE NAME AND PHONE NUMBER:

NAME/RELATIONSHIP AND PHONE NUMBER:

NAME/RELATIONSHIP AND PHONE NUMBER:

This will remain in effect until you rescind it in writing.

PATIENT AND/OR PATIENT'S REPRESENTATIVE SIGNATURE

☐ I do not consent

for my provider to leave detailed telephone messages regarding my personal health information (PHI).

PATIENT AND/OR PATIENT'S REPRESENTATIVE SIGNATURE

☐ I do not consent

for my provider to communicate messages regarding my personal health information (PHI) to family members.

PATIENT AND/OR PATIENT'S REPRESENTATIVE SIGNATURE:

☐ Revocation of Prior Consent:

I wish to rescind or stop any prior consent to leave detailed telepjone messages or communicate with family regarding my personal health information (PHI).

PATIENT AND/OR PATIENT'S REPRESENTATIVE SIGNATURE

Privacy and Billing Consent Form

This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your health care information.

Consent Related to Privacy Notice:

I have had a chance to review the Practice Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.

Consent for Care:

I, $(patient.name) with my signature, authorize (this practice), and any employee working under the direction of the physician, to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but not limited to) preventative, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body and the sale or dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professionals for care and treatment.

Consent for Release of Information and Assignment of Benefits:

I also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities. I consent to assign all payments for services directly to this practice. I further consent to the use for any practice operational needs as identified in the Practice Privacy Notice.

Financial Policy:

We appreciate you choosing us for your healthcare. We will adhere to the following financial policy in order to consistently deliver high quality care and services. The patient/responsible party assumes responsibility to ensure that the financial obligation is fulfilled for the health care services received.

- I understand that I am responsible for all co-payments, amounts applied to deductibles, and other amounts that may be deemed my responsibility by the payment sources, as required by my contract with my insurance plan and state regulations.
- I understand that if I have an insurance co-payment, I am expected to make payment when checking in for my appointment.
- I understand that my contract with my insurance entity may or may not cover some services. All insurance policies are not the same. They vary by employer group. $(practice.name) is not responsible or able to know every policy available. It is my responsibility to verify applicable coverage prior to receiving the services. For example, not all health plans include screenings as a benefit. If I seek care outside of the contract terms, I am aware that I may be responsible for all charges that are incurred.

Thank you for your understanding and cooperation with this policy. It is our privilege to provide your medical care.

I have read and understand the Consents and Financial Policy stated above and agree to accept full responsibility as described above.

PATIENT/RESPONSIBLE PARTY

Patient Consent

For use and/or disclosure of Protected Health Information to carry out treatment, payment and healthcare operations.

$(patient.name) hereby states that by signing this Consent I acknowledge and agree as follows:

1.The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out is health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2.The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3.I understand that, and consent to, the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.

4.The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.

5.I understand that I have a right to request that the Practice restrict how my **PHI** is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

6.I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.

7.I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

8.I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

SIGNATURE OF PATIENT

Formularios de Consentimiento

Para el uso y / o divulgación de Información de salud protegida para llevar a cabo operaciones de tratamiento, pago y atención médica.

$ (nombre del paciente) declara que al firmar este consentimiento, reconozco y acepto lo siguiente:

1.El aviso de privacidad de la práctica me fue proporcionado antes de firmar este consentimiento. El Aviso de Privacidad incluye una descripción completa de los usos y / o divulgaciones de mi información de salud protegida (PHI) necesaria para que la Práctica me proporcione tratamiento, y también es necesaria para que la Práctica obtenga el pago por ese tratamiento y lleve a cabo la operaciones de cuidado. La práctica me explicó que el aviso de privacidad estará disponible para mí en el futuro a petición mía. La práctica me ha explicado además mi derecho a obtener una copia del Aviso de privacidad antes de firmar este Consentimiento, y me ha alentado a leer el Aviso de privacidad cuidadosamente antes de firmar este Consentimiento.

2. La Práctica se reserva el derecho de cambiar sus prácticas de privacidad que se describen en su Aviso de Privacidad, de acuerdo con la ley aplicable.

3. Entiendo y acepto los siguientes recordatorios de citas que utilizará la Práctica: a) una postal enviada por correo a la dirección que proporcioné; yb) llamar por teléfono a mi casa y dejar un mensaje en mi contestador automático o con la persona que contesta el teléfono.

4. La práctica puede usar y / o divulgar mi PHI (que incluye información sobre mi salud o condición y el tratamiento que se me proporcionó) para que la práctica me trate y obtenga pago por ese tratamiento, y según sea necesario para la práctica de llevar a cabo sus operaciones específicas de atención médica.

5. Entiendo que tengo derecho a solicitar que la práctica restrinja cómo se utiliza y / o divulga mi PHI para llevar a cabo operaciones de tratamiento, pago y / o atención médica. Sin embargo, la práctica no está obligada a aceptar ninguna restricción que haya solicitado. Si la práctica acepta una restricción solicitada, entonces la restricción es vinculante para la práctica.

6. Entiendo que este consentimiento es válido por siete años. Además, entiendo que tengo el derecho de revocar este Consentimiento, por escrito, en cualquier momento para todas las transacciones futuras, en el entendido de que dicha revocación no se aplicará en la medida en que la Práctica ya haya tomado medidas basándose en este consentimiento.

7. Entiendo que si revoco este consentimiento en cualquier momento, la práctica tiene el derecho de negarse a tratarme.

8. Entiendo que si no firmo este consentimiento que acredite mi consentimiento a los usos y divulgaciones que se me describieron anteriormente y que figuran en el aviso de privacidad, entonces la práctica no me tratará.

He leído y entiendo el aviso anterior, y todas mis preguntas han sido contestadas a mi entera satisfacción de una manera que pueda entender.

SIGNATURE OF PATIENT

Formulario de consentimiento de privacidad y facturación

La Ley de Portabilidad y Responsabilidad del Seguro Médico de 1996 exige este consentimiento para informarle sobre sus derechos de privacidad con respecto a su información de atención médica.

Consentimiento relacionado con el aviso de privacidad:

I $ (patient.name) tuvo la oportunidad de revisar el Aviso de privacidad de la práctica como parte de este proceso de registro. Entiendo que los términos del Aviso de Privacidad pueden cambiar y puedo obtener estos avisos revisados poniéndome en contacto con la práctica por teléfono o por escrito. Entiendo que tengo derecho a solicitar la divulgación de mi información protegida de salud (PHI). También tengo derecho a restringir cómo se divulga esta información, pero esta práctica no está obligada a aceptar mis restricciones. Si acepta mis restricciones sobre el uso de PHI, está obligado por ese acuerdo.

Consentimiento para el cuidado:

I, $ (patient.name) con mi firma, autorizo (esta práctica) y cualquier empleado que trabaje bajo la dirección del médico, para proporcionar atención médica para mí o para este paciente del cual soy el tutor legal. Esta atención médica puede incluir servicios y suministros relacionados con mi salud (o la persona identificada) y puede incluir (entre otros) servicios preventivos, de diagnóstico, terapéuticos, de rehabilitación, de mantenimiento, cuidados paliativos, asesoramiento, evaluación o revisión del estado físico o mental. / función del cuerpo y la venta o dispensación de drogas, dispositivos, equipos u otros artículos necesarios y de acuerdo con una prescripción. Este consentimiento incluye el contacto y la discusión con otros profesionales de atención médica para la atención y el tratamiento.

Consentimiento para divulgación de información y asignación de beneficios:

También autorizo esta práctica para proporcionar información a la (s) compañía (s) de seguros identificadas para todas las actividades de pago. Doy mi consentimiento para asignar todos los pagos por servicios directamente a esta práctica. Además, doy mi consentimiento para el uso de cualquier práctica de las necesidades operativas identificadas en el Aviso de privacidad de la práctica.

Política financiera:

Le agradecemos que nos haya elegido para su atención médica. Cumpliremos con la siguiente política financiera a fin de brindar atención y servicios de alta calidad consistentemente. El paciente / la parte responsable asume la responsabilidad de garantizar que la obligación financiera se cumpla para los servicios de atención médica recibidos.

Entiendo que soy responsable de todos los copagos, los montos aplicados a los deducibles y otros montos que las fuentes de pago consideren mi responsabilidad, según lo exige mi contrato con mi plan de seguro y las reglamentaciones estatales.

Entiendo que si tengo un copago de seguro, se espera que realice el pago al momento de registrarse para mi cita.

Entiendo que mi contrato con mi entidad aseguradora puede o no cubrir algunos servicios. Todas las pólizas de seguro no son lo mismo. Varían según el grupo de empleador. $ (practice.name) no es responsable ni puede conocer todas las políticas disponibles. Es mi responsabilidad verificar la cobertura aplicable antes de recibir los servicios. Por ejemplo, no todos los planes de salud incluyen evaluaciones como un beneficio. Si busco atención médica fuera de los términos del contrato, soy consciente de que puedo ser responsable de todos los cargos incurridos.

Gracias por su comprensión y cooperación con esta política. Es nuestro privilegio brindarle atención médica.

He leído y entiendo los Consentimientos y la Política Financiera indicados anteriormente y acepto la plena responsabilidad según lo descrito anteriormente.

PACIENTE / PARTE RESPONSABLE

Aviso de prácticas de privacidad de HIPAA

ESTE AVISO DESCRIBE CÓMO SE PUEDE UTILIZAR Y DIVULGAR SU INFORMACIÓN MÉDICA Y CÓMO PUEDE TENER ACCESO A ESTA INFORMACIÓN. POR FAVOR REVISE CON CUIDADO.

Comprendemos la importancia de la privacidad y nos comprometemos a mantener la confidencialidad de su información médica. Hacemos un registro de la atención médica que proporcionamos y podemos recibir dichos registros de otros. Usamos estos registros para proporcionar o habilitar a otros proveedores de atención médica para que brinden atención médica de calidad, para obtener el pago de los servicios que se le brindan según lo permitido por su plan de salud y para cumplir con nuestras obligaciones legales y profesionales de operar esta práctica médica adecuadamente. La ley nos exige mantener la privacidad de la información de salud protegida, proporcionar a los individuos un aviso de nuestras obligaciones legales y prácticas de privacidad con respecto a la información de salud protegida, y notificar a las personas afectadas después de una violación de la información de salud protegida no segura. Este aviso describe cómo podemos usar y divulgar su información médica. También describe sus derechos y nuestras obligaciones legales con respecto a su información médica. Si tiene alguna pregunta sobre este Aviso, comuníquese con nuestro Oficial de Privacidad mencionado anteriormente.

TABLA DE CONTENIDO

¿Cómo esta práctica médica puede utilizar o divulgar su información de salud?

- Esta práctica médica recopila información de salud sobre usted y la almacena en un cuadro [y en una computadora] [y en un registro electrónico de salud / registro personal de salud]. Este es su registro médico. El registro médico es propiedad de esta práctica médica, pero la información en el registro médico le pertenece. La ley nos permite usar o divulgar su información de salud para los siguientes propósitos:

  1. Tratamiento. Usamos su información médica para brindarle atención médica. Divulgamos información médica a nuestros empleados y otras personas que participan en la prestación de la atención que necesita. Por ejemplo, podemos compartir su información médica con otros médicos u otros proveedores de atención médica que proporcionarán servicios que nosotros no brindamos. O podemos compartir esta información con un farmacéutico que la necesite para dispensarle una receta, o un laboratorio que realice una prueba. También podemos divulgar información médica a miembros de su familia u otras personas que puedan ayudarlo cuando esté enfermo o lesionado, o después de su muerte.

  2. Pago. Usamos y divulgamos su información médica para obtener el pago por los servicios que brindamos. Por ejemplo, le brindamos a su plan de salud la información que requiere antes de que nos pague. También podemos divulgar información a otros proveedores de atención médica para ayudarlos a obtener el pago de los servicios que le han brindado.

  3. Operaciones de cuidado de la salud. Podemos utilizar y divulgar información médica sobre usted para operar esta práctica médica. Por ejemplo, podemos usar y divulgar esta información para revisar y mejorar la calidad de la atención que proporcionamos, o la competencia y las calificaciones de nuestro personal profesional. O podemos usar y divulgar esta información para que su plan de salud autorice servicios o referencias. También podemos usar y divulgar esta información según sea necesario para revisiones médicas, servicios legales y auditorías, incluidos detección de fraude y abuso y programas de cumplimiento y planificación y gestión comercial. También podemos compartir su información médica con nuestros "socios comerciales", como nuestro servicio de facturación, que realizan servicios administrativos para nosotros. Tenemos un contrato por escrito con cada uno de estos socios comerciales que contiene términos que los exigen a ellos y a sus subcontratistas para proteger la confidencialidad y seguridad de su información de salud protegida. También podemos compartir su información con otros proveedores de atención médica, centros de información o planes de salud que tengan una relación con usted, cuando soliciten esta información para ayudarlos con su evaluación de calidad y actividades de mejora, sus actividades de seguridad del paciente, su población. esfuerzos basados en mejorar la salud o reducir los costos de atención médica, su protocolo de desarrollo, gestión de casos o actividades de coordinación de atención, su revisión de competencia, calificaciones y desempeño de profesionales de la salud, sus programas de capacitación, sus actividades de acreditación, certificación o licenciamiento, o sus cuidado de la salud y detección de abuso y esfuerzos de cumplimiento.

  4. [Opcional]: Recordatorios de citas. Podemos usar y divulgar información médica para contactarlo y recordarle sobre citas. Si no está en casa, podemos dejar esta información en su contestador automático o en un mensaje dejado con la persona que contesta el teléfono.

  5. Registrarse en la hoja. Podemos utilizar y divulgar información médica sobre usted haciendo que se registre cuando llegue a nuestra oficina. También podemos llamar su nombre cuando estemos listos para verlo.

  6. Notificación y comunicación con la familia. Podemos divulgar su información de salud para notificar o ayudar a notificar a un miembro de la familia, su representante personal u otra persona responsable de su cuidado sobre su ubicación, su condición general o, a menos que nos haya instruido de otra manera, en el caso de su fallecimiento. En caso de un desastre, podemos divulgar información a una organización de ayuda para que puedan coordinar estos esfuerzos de notificación. También podemos divulgar información a alguien que esté involucrado con su atención o que ayude a pagar su atención. Si puede y está disponible para aceptar u objetar, le ofreceremos la oportunidad de formular una objeción antes de hacer estas divulgaciones, aunque podemos divulgar esta información en un desastre incluso por encima de su objeción si creemos que es necesario para responder a las circunstancias de emergencia. . Si no puede o no está disponible para aceptar u objetar, nuestros profesionales de la salud utilizarán su mejor juicio para comunicarse con su familia y con los demás.

7. Mercadotecnia (Marketing). Siempre que no recibamos ningún pago por hacer estas comunicaciones, podemos ponernos en contacto con usted para brindarle información sobre productos o servicios relacionados con su tratamiento, administración de casos o coordinación de atención, o para dirigir o recomendar otros tratamientos, terapias, proveedores de atención médica o entornos de la atención que puede ser de interés para usted. De manera similar, podemos describir productos o servicios proporcionados por esta práctica e indicarle en qué planes de salud participa esta práctica. También podemos alentarlo a mantener un estilo de vida saludable y obtener pruebas recomendadas, participar en un programa de manejo de enfermedades, proporcionarle pequeños obsequios, informarle sobre los programas de salud patrocinados por el gobierno o alentarlo a comprar un producto o servicio cuando lo veamos, por lo cual se nos puede pagar. Finalmente, podemos recibir una compensación que cubre nuestro costo de recordarte que tomes y vuelvas a llenar tu medicamento, o que comuniques algo sobre un medicamento o biológico que actualmente se te recete. De lo contrario, no utilizaremos ni divulgaremos su información médica con fines de comercialización ni aceptaremos ningún pago por otras comunicaciones de marketing sin su autorización previa por escrito. La autorización revelará si recibimos alguna compensación por cualquier actividad de mercadeo que usted autorice, y detendremos cualquier actividad futura de mercadeo en la medida en que revoque dicha autorización.

8. Venta de información de salud. No venderemos su información de salud sin su autorización previa por escrito. La autorización revelará que recibiremos una compensación por su información de salud si nos autoriza a venderla, y detendremos cualquier venta futura de su información en la medida en que revoque dicha autorización.

9. Requerido por la ley. Según lo exige la ley, usaremos y divulgaremos su información de salud, pero limitaremos nuestro uso o divulgación a los requisitos pertinentes de la ley. Cuando la ley nos exija denunciar el abuso, la negligencia o la violencia doméstica, o responder a procedimientos judiciales o administrativos, o a funcionarios encargados de hacer cumplir la ley, seguiremos cumpliendo con los requisitos establecidos a continuación con respecto a esas actividades.

10. Salud pública. Es posible que, a veces, la ley nos exija divulgar su información de salud a las autoridades de salud pública para fines relacionados con: la prevención o el control de enfermedades, lesiones o discapacidades; reportar abuso o negligencia de niños, ancianos o adultos dependientes; reportar violencia doméstica; informar a la Administración de Alimentos y Medicamentos sobre los problemas con los productos y las reacciones a los medicamentos; y reportar la exposición a enfermedades o infecciones. Cuando informamos sospecha de abuso de adultos mayores o adultos dependientes o violencia doméstica, le informaremos a usted o a su representante personal sin demora, a menos que nuestro mejor criterio profesional: creemos que la notificación lo pondría en riesgo de daño grave o requeriría informar a un representante personal que creemos es responsable del abuso o daño.

11. Actividades de supervisión de la salud. Es posible que, a veces, la ley nos exija divulgar su información de salud a las agencias de supervisión de la salud durante el curso de las auditorías, investigaciones, inspecciones, licencias y otros procedimientos, sujeto a las limitaciones impuestas por la ley.

12. Procedimientos judiciales y administrativos. Podemos, y en ocasiones estamos obligados por ley, a divulgar su información de salud en el transcurso de cualquier procedimiento administrativo o judicial en la medida expresamente autorizada por un tribunal o una orden administrativa. También podemos divulgar información sobre usted en respuesta a una citación, solicitud de descubrimiento u otro proceso legal si se han realizado esfuerzos razonables para notificarle la solicitud y usted no se opuso, o si sus objeciones han sido resueltas por un tribunal o una orden administrativa. .

13. Aplicación de la ley. Podemos, y en ocasiones la ley nos exige, divulgar su información de salud a un funcionario encargado de hacer cumplir la ley para fines tales como identificar o localizar a un sospechoso, fugitivo, testigo material o persona desaparecida, cumplir con una orden judicial, orden de arresto, citación del gran jurado y otros fines de aplicación de la ley.

14. Juez de instrucción (Coroners). Es posible que, a menudo, la ley nos exija que divulguemos su información de salud a los forenses en relación con sus investigaciones de muertes.

15. Donación de órganos o tejidos. Podemos divulgar su información de salud a organizaciones involucradas en la adquisición, almacenamiento o trasplante de órganos y tejidos.

16. Seguridad pública. Podemos, y en ocasiones estamos obligados por ley, a divulgar su información de salud a las personas apropiadas para prevenir o disminuir una amenaza grave e inminente a la salud o seguridad de una persona en particular o del público en general.

17. Prueba de inmunización. Revelaremos la prueba de vacunación a una escuela que se requiere tener antes de admitir a un estudiante en el que haya aceptado la divulgación en su nombre o el de su dependiente.

18. Funciones gubernamentales especializadas. Podemos divulgar su información de salud para propósitos militares o de seguridad nacional o para instituciones correccionales o agentes del orden público que lo tengan bajo su custodia legal.

19. Compensación del trabajo. Podemos divulgar su información de salud según sea necesario para cumplir con las leyes de compensación laboral. Por ejemplo, en la medida en que su cuidado esté cubierto por la compensación laboral, le haremos informes periódicos a su empleador sobre su condición. También estamos obligados por ley a informar casos de lesiones ocupacionales o enfermedades ocupacionales al empleador o asegurador de compensación laboral.

20. Cambio de propiedad. En el caso de que esta práctica médica se venda o se fusione con otra organización, su información / registro de salud pasará a ser propiedad del nuevo propietario, aunque mantendrá el derecho de solicitar que se transfieran copias de su información médica a otro médico o médico grupo.

21. Notificación de alcance. En el caso de una violación de la información de salud protegida no segura, se lo notificaremos según lo exija la ley. Si nos ha proporcionado una dirección de correo electrónico actual, podemos usar el correo electrónico para comunicar información relacionada con el incumplimiento. En algunas circunstancias, nuestro socio comercial puede proporcionar la notificación. También podemos proporcionar notificaciones por otros métodos, según corresponda. [Nota: solo use la notificación por correo electrónico si está seguro de que no contendrá la PHI y no revelará información inapropiada. Por ejemplo, si su dirección de correo electrónico es "digestivediseaseassociates.com", un correo electrónico enviado con esta dirección podría, si se intercepta, identificar al paciente y su afección.]

(Agregue las siguientes tres actividades, o cualquiera de las tres, si la organización participa o tiene la intención de participar en estas actividades).

22. Investigación. Podemos divulgar su información de salud a investigadores que realicen investigaciones con respecto a los cuales no se requiera su autorización escrita según lo aprobado por una Junta de Revisión Institucional o una junta de privacidad, de conformidad con la ley vigente.

B ¿Cuándo esta práctica médica no puede usar, o divulgar su información de salud?

- A excepción de lo descrito en este Aviso de prácticas de privacidad, esta práctica médica, de conformidad con sus obligaciones legales, no usará ni divulgará información de salud que lo identifique sin su autorización por escrito. Si autoriza esta práctica médica para usar o divulgar su información de salud para otro fin, puede revocar su autorización por escrito en cualquier momento.

C. Sus derechos de información de salud

1. Derecho a solicitar protecciones de privacidad especiales. Usted tiene derecho a solicitar restricciones sobre ciertos usos y divulgaciones de su información de salud mediante una solicitud escrita que especifique qué información quiere limitar y qué limitaciones hay en nuestro uso o divulgación de esa información que desea imponer. Si nos dice que no divulguemos información a su plan de salud comercial con respecto a los artículos o servicios de atención médica que pagó en su totalidad de su bolsillo, cumpliremos con su solicitud, a menos que tengamos que divulgar la información por motivos de tratamiento o legales. . Nos reservamos el derecho de aceptar o rechazar cualquier otra solicitud, y le notificaremos nuestra decisión.

2. Derecho a solicitar comunicaciones confidenciales. Tiene derecho a solicitar que reciba su información de salud de una manera específica o en un lugar específico. Por ejemplo, puede solicitar que le enviemos información a una cuenta de correo electrónico en particular oa la dirección de su trabajo. Cumpliremos con todas las solicitudes razonables enviadas por escrito que especifiquen cómo o dónde desea recibir estas comunicaciones.

3. Derecho a inspeccionar y copiar. Usted tiene el derecho de inspeccionar y copiar su información de salud, con excepciones limitadas. Para acceder a su información médica, debe enviar una solicitud por escrito que detalle a qué información desea acceder, si desea inspeccionarla u obtener una copia de ella, y si desea una copia, su forma y formato preferidos. Le proporcionaremos copias en su formato y formato solicitado si se pueden producir fácilmente, o le proporcionaremos un formato alternativo que considere aceptable, o si no podemos aceptarlo y mantenemos el registro en un formato electrónico, su elección de un formato legible electrónico o en papel. También enviaremos una copia a cualquier otra persona que designe por escrito. Cobraremos una tarifa razonable que cubra nuestros costos de mano de obra, suministros, gastos de envío y, si se solicita y se acuerda con anticipación, el costo de preparar una explicación o un resumen. Podemos denegar su solicitud en circunstancias limitadas. Si denegamos su solicitud de acceso a los registros de su hijo o los registros de un adulto incapacitado que está representando porque consideramos que permitir el acceso sería razonablemente probable que cause un daño sustancial al paciente, tendrá derecho a apelar nuestra decisión.

4. Derecho a Enmendar o Complementar. Tiene derecho a solicitar que modifiquemos su información de salud que usted cree que es incorrecta o incompleta. Debe hacer una solicitud para enmendar por escrito e incluir los motivos por los cuales cree que la información es incorrecta o incompleta. No estamos obligados a cambiar su información de salud, y le brindaremos información sobre la denegación de esta práctica médica y sobre cómo puede estar en desacuerdo con la denegación. Podemos rechazar su solicitud si no tenemos la información, si no la creamos (a menos que la persona o entidad que creó la información ya no esté disponible para realizar la modificación), si no se le permite inspeccionar o copiar la información en cuestión, o si la información es precisa y completa como está. Si denegamos su solicitud, puede enviar una declaración por escrito de su desacuerdo con esa decisión, y podemos, a su vez, preparar una refutación por escrito. Toda la información relacionada con cualquier solicitud de modificación se mantendrá y divulgará junto con cualquier divulgación posterior de la información impugnada.

5. Derecho a un informe de divulgaciones. Usted tiene derecho a recibir un informe de las divulgaciones de su información médica realizadas por esta práctica médica, excepto que esta práctica médica no tiene que dar cuenta de las divulgaciones proporcionadas a usted o de acuerdo con su autorización escrita, o como se describe en los párrafos 1 (tratamiento), 2 (pago), 3 (operaciones de atención médica), 6 (notificación y comunicación con la familia) y 18 (funciones gubernamentales especializadas) de la Sección A de este Aviso de Prácticas de Privacidad o divulgaciones para fines de investigación o salud pública que excluyen identificadores directos del paciente, o que son incidentales a un uso o revelación permitidos o autorizados por la ley, o las divulgaciones a una agencia de supervisión de la salud u oficial de cumplimiento de la ley en la medida en que esta práctica médica haya recibido el aviso de esa agencia u oficial sería razonablemente probable que impida sus actividades.

6. Derecho a una copia en papel o electrónica de este aviso. Usted tiene derecho a recibir notificación de nuestros deberes legales y prácticas de privacidad con respecto a su información de salud, incluido el derecho a una copia en papel de este Aviso de Prácticas de Privacidad, incluso si previamente ha solicitado su recepción por correo electrónico.

Si desea obtener una explicación más detallada de estos derechos o si desea ejercer uno o más de estos derechos, comuníquese con nuestro Oficial de privacidad que figura en la parte superior de este Aviso de prácticas de privacidad.

D. Cambios a este aviso de prácticas de privacidad

Nos reservamos el derecho de modificar este Aviso de prácticas de privacidad en cualquier momento en el futuro. Hasta que se realice dicha modificación, la ley nos exige que cumplamos con los términos de este Aviso actualmente en vigencia. Después de que se realice una modificación, la Notificación de Protección de Privacidad revisada se aplicará a toda la información de salud protegida que mantenemos, independientemente de cuándo fue creada o recibida. Mantendremos una copia del aviso actual publicado en nuestra área de recepción, y una copia estará disponible en cada cita. [Para las prácticas con sitios web agregue: también publicaremos el aviso actual en nuestro sitio web).
E. Quejas

Las quejas sobre este Aviso de Prácticas de Privacidad o sobre cómo esta práctica médica maneja su información de salud deben dirigirse a nuestro Oficial de Privacidad que figura en la parte superior de este Aviso de Prácticas de Privacidad.

Si no está satisfecho con la forma en que esta oficina maneja una queja, puede enviar una queja formal a:

[inserte el nombre y la información de contacto de la Oficina de Derechos Civiles local del DHHS]
OCRMail@hhs.gov

El formulario de queja se puede encontrar en www.hhs.gov/ocr/privacy/hipaa/complaints/hipcompla (http://www.hhs.gov/ocr/privacy/hipaa/complaints/hipcompla) ....

No será penalizado de ninguna manera por presentar una queja

FIRMA DEL PACIENTE / TUTOR