Patient HIPAA Acknowledgement and Consent Form

Patient Name: _____

Date of Birth: _____

Thank you for choosing us as your health care provider. We are committed to excellent patient care and the compliance with Health Insurance Portability and Accountability Act (HIPAA) guidelines. The following is an explanation of our Financial Policy and Agreement, which you must read and sign prior to any current and future medical evaluation or treatment in this office. All patients must also complete the information and insurance form before seeing a provider.

- Each patient is responsible for his or her own bill.
- Payment of all insurance co-payments and deductibles is payable at the time medical services are rendered unless arrangements are made in advance.
- Your insurance policy is a contract between you and your insurance company. We are not party to that contract. As a courtesy, this office will submit bills to your insurance carrier. In order to facilitate claims processing, you must provide all insurance policy information and changes to our office immediately. Your bill is your responsibility whether your insurance pays or not. At times you may need to contact your insurance carrier regarding slow or non-payment of your insurance claim.
- You are responsible for knowing what your insurance covers and which providers and networks are covered under your health insurance plan. Any services provided, but not covered by your insurance company, will be your responsibility to pay.
- When scheduled for a preventive care visit, your provider will address the customary services and screenings defined as preventive care. If you would like to discuss an additional health issue, you may have to schedule a separate appointment time. If time allows and your provider addresses your concern that same day, you will be billed for two separate charges on same day.
- If your insurance company has not paid your account in full within 60 days, you are responsible to pay the outstanding balance without further delay. Please see the credit card on file policy below.

USUAL AND CUSTOMARY RATES

Our rates for medical services reflect the usual and customary rates in the community. Unless we have accepted an alternate fee schedule from your insurance company, you are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates for medical services.

AUTHORIZATION TO PAY BENEFITS

I further authorize and direct said agency, attorney or Insurance company to pay from the proceeds of benefits of any recovery of insurance payments in my case, directly to the providers of this office for their professional services rendered. I understand this in no way relieves me from my personal responsibility for paying my provider when a statement is rendered. It is understood that the signing of this form does not prohibit customary monthly billings.

I understand and agree to the policies stated in paragraphs above.

Signature: _____ Date: _____

CREDIT CARD ON FILE AGREEMENT

We have implemented a procedure which enables you to maintain your credit card information securely on file with The Care Group PC. In providing us with your credit card information, you are giving The Care Group PC permission to automatically charge your credit card on file for co-payments, outstanding balance, and services not covered by your insurance company.

Co-payments are due at time of the office visit.

After your insurance company distributes the Explanation of Benefits (EOB), which specifies its portion of your bill and identifies the patient responsibility portion, any remaining balance will be due within one week. The Care Group PC will notify you via your preferred method of contact, phone and/or e-mail. If The Care Group PC does not receive a response from you or your payment in full, at that time, any balance owed will be charged to your credit card. A receipt for the charge will be e-mailed to you. This process in no way compromises your ability to dispute a charge or question your insurance company's determination of payment.

This card will only be authorized for the use of the credit cardholder. This agreement will remain in effect unless other payment arrangements are approved by The Care Group PC.

I,_____, authorize The Care Group PC to charge this credit card account for payments due on my account for services rendered. I agree to update any information regarding this account as needed.

☐ American Express ☐ MasterCard ☐ Discover ☐ Visa

Last 4 digits of Card Number _____

Expiration Date (MM/YY) _____

Cardholder Name (Print) _____

Cardholder Signature _____ Date: _____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize this office to release all information concerning my medical treatment to my insurance carriers and to requesting referring providers (if any). I acknowledge that I have been provided access to a copy of the HIPAA Policies and Practices and may request a written copy of said policy any time I wish.

CONSENT TO THE USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION (PHI) FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS (TPO)

I,_____, understand that as part of my health care, The Care Group PC originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information servesas:

- A basis for planning my care and treatment.
- A means of communicating among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand a NOTICE OF PRIVACY POLICIES is available, which provides a more complete description of PHI uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing the consent (visit www.thecaregrouppc.com)
- The right to request restrictions as to how my PHI may be used or disclosed to carry out Treatment, Payment and Healthcare Operations (TPO).

I understand that The Care Group PC is not required to agree to the restrictions requested. I further understand that I may revoke this consent in writing, except to the extent of action already taken by the clinic. If I wish to make changes to this consent, I agree to do so in writing. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I wish to have the following restrictions to the use or disclosure of my PHI:

_____

_____

I wish the following individual(s) to have ☐ **full** ☐ **limited** (*check one*) access to my PHI:

If limited is checked, please note the extent of information that should be available to this individual, e.g., test results, medications, diagnosis, treatment, appointments.

Name Relationship

_____

_____

I further direct The Care Group to contact me regarding lab results, appointment reminders, or billing and payment through the following methods of contact noted below. Please check preferred method of contact.

☐ Contact me by Phone at _____ May we leave a message? ☐ Yes ☐ No

☐ Contact me by E-mail at _____ (Please print)

☐ Either contact method is acceptable

Would you like to receive articles written by Dr. Guillory on relevant health topics? ☒ Yes ☐ No

By signing below, I am consenting to allow The Care Group PC to use and disclose my PHI to carry outTPO.

_____ _____

Signature Date

Rev. 2/21/19