



## Notice of Patient's Rights and Responsibilities

### **Patent Rights**

- ❖ Patients have the right to receive respectful, compassionate care in a safe and non-threatening environment regardless of their age, appearance, diagnosis, addiction, disabilities, gender identity, language, income, national origin, race, religion, sexual orientation, or weight/size.
- ❖ Patients have the right to be informed about their diagnosis and prognosis, if it is known, and to be informed about the risks and benefits of all treatment offered.
- ❖ Patients have the right to confidentiality and can expect that communications and records of their care are confidential, unless disclosure is permitted or required by law.
- ❖ Patients have the right to examine and receive an explanation of their itemized bill, including 3rd party reimbursement regardless of the source of payment.
- ❖ Patients have the right to voice their concerns about the care they receive. If their concern is not resolved to their satisfaction, they may contact.
- ❖ Patients have the right to privacy during medical treatment within the capacity of the facility.
- ❖ Patients have the right to request the presence of an escort during any type of examination.

- ❖ Patients and any family or friends they designate have the right to participate in decisions about their care, including the right to refuse treatment.
- ❖ Patients have the right to communicate that they can understand, including provision of language interpretation services, if needed at no cost to them.

### **PATIENT RESPONSIBILITIES**

- ❖ Patients are expected to provide complete and accurate information regarding your name, date of birth, address, telephone number and insurance carrier, when requested.
- ❖ Patients are expected to keep schedule appointments, be on time and call ahead of time if they cannot keep an appointment.
- ❖ Patients are expected to ask questions when they do not understand their treatment plan.
- ❖ Patients are expected to treat all staff and other patients with respect and not to behave un a disruptive, disrespectful, or threatening manner. Our staff will not tolerate any type of verbal abuse.
- ❖ Patients are responsible for all outstanding balances to be paid in a timely matter.

Patients can reach our Compliance Office for any concerns at

2620 Mineral Springs Ave Suite A.

Knoxville, TN 37917

865-247-4809 ext. 1001

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_



Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Would you like to receive appointment confirmations via text? Yes or No

Email: \_\_\_\_\_

**Please circle Options Below**

Male or Female      Marital Status: Single   Married   Divorced   Widow

Reason for Visit: \_\_\_\_\_

Were you referred to our office, if so by who? \_\_\_\_\_ - \_\_\_\_\_

Insurance Information: **Name of Insurance:** \_\_\_\_\_

**If you are not the primary insurance holder, please complete the information below**

Name of Policy Holder: \_\_\_\_\_ DOB: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

- ❖ I hereby authorize Mark Kirshner Orthotics to obtain records from the other sources as may be needed in the treatment of this patient.
- ❖ I hereby authorize payment of insurance and benefits otherwise due to me to be made directly to Mark Kirshner Orthotics. I understand that I am responsible for any amount not covered by insurance company.
- ❖ I understand that if an outstanding balance is not taken care of within 180 days after date of service, Mark Kirshner Orthotics reserves the right to send the delinquent account to the collections department. Once sent an additional 25% collection fee will be added to the account. A copy of this information shall be as valid as the original

Signature \_\_\_\_\_ Date: \_\_\_\_\_



## HIPPA CONTACT CONSENT FORM

We understand that medical information about you and your health is personal and we are committed to protecting it. In order to comply with HIPAA Health Insurance Portability and Accountability Act. Privacy Notice of 1990 we are requesting that you designate to whom we may disclose specifics of your health information, the laboratory and radiology results, necessarily follow up appointments. Etc.

What is the Primary phone number you would like us to contact you on?

\_\_\_\_\_ May we leave a message at this phone number? Yes or No

If you are unavailable is there someone with whom we are authorized to speak with?

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **HIPAA INFORMATION AND CONSENT FORM The Health Insurance Portability and Accountability Act**

**(HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14,2003. Many of the policies have been our practice for years. This from is a friendly version. A more complete text is posted in the office. What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protect Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is avail form the U.S. department of Health and Human Services. [www.hhs.gov](http://www.hhs.gov) We have adopted the following policies:**

- 1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically include the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information. Which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in admirative areas such as the front office, examination room, etc. Those records will not be available to person other that office staff. You agree to the normal procedures utilized within the office for the handing of charts, patient records, PHI and other documents or information.**
- 2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, email, US mail, or by any mean convenient for the practice and/or requested by you. We may send you other communication informing you of changes to office policy and new Technology that you might find valuable or informative.**
- 3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.**
- 4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance pares in normal performance of their duties.**
- 5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.**
- 6. Your confidential information will not be used for the purpose of marketing or advertising of products, good or reviews.**
- 7. We agree to provide patients with access to their records in accordance with state and federal laws.**
- 8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.**
- 9. You have the right to request restrictions in the use of your protected health information and to request change in certain polices used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.**

**Signature \_\_\_\_\_ Date \_\_\_\_\_**



## **Cancellation/No show policy for Scheduled Appointments**

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, do to seemingly “full” appointment Calander. If an appointment is not cancelled at least 24 hours in advance you will be charged a fifty-dollar (\$50) fee, this will not be covered by your insurance company.

### **Scheduled Appointments**

We understand that delays can happen, however we must try to keep the other patients and the clinic on time. If a patient is more than 15 minutes past their scheduled time, we will have to reschedule the appointment.

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### **Account Balances**

We will require that patients with self-pay balances do pay their account balances to zero prior to receiving further services by our office. Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to the office manager. Patients with balances of \$100 must make payment arrangements prior to future appointments being made.

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_