Sussex NP, LLC
21209 Shell Station Road
Frankford, DE 19945
Office #: 302-321-5611 Fax#: 302-406-1892

Authorization to Release/Receive Confidential Information

Name: _____

Social Security Number: _____

Date of Birth: _____

I, _____ hereby authorize Sussex NP, LLC to disclose Information to and to receive information from:

Name of Provider or Facility: _____

Address: _____

Phone Number or Fax Number: _____

If under 18 parent or legal guardian please sign here: _____

By Initialing the boxes below, I am Authorizing Sussex NP, LLC to send or receive my Information:

Information Requested	Initials
Medical Records	
Laboratory and X-Ray Results	
Prescription Medication History	
Progress Notes	
Hospital Records	

I understand that my records are protected under the Federal privacy regulation within the Health Insurance Portability and Accountability Act (HIPAA) I understand that my health information that is specified will be disclosed pursuant to this authorization and that it may no longer be protected by the HIPAA privacy law. Sussex NP, LLC may disclose confidential information to a provider of support services only under written agreement in which all providers understand they will safeguard and not further disclose the information.

Sussex NP, LLC will use my information to the minimum necessary in order to coordinate care, deliver services and to operate as a sound business entity. Sussex NP, LLC employees, auditors, Insurance Companies, and other oversight and regulatory bodies may have access to this information

I further understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it.

This authorization is valid from the date in which I sign this and will remain in effect until whichever of the following events occur 1) the date I revoke this authorization 2) the date I am discharged from Sussex NP, LLC.

Print Name: _____

Signature: _____

Date: _____

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

● Protected health information may be disclosed or used for treatment, payment, or healthcare operations.

● The practice reserves the right to change the privacy policy as allowed by law.

● The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.

● The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.

● The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If you would like to allow medical information to be shared with family/friend, please list here:

_____

Name Relationship Phone

_____

Name Relationship Phone

Name Relationship Phone

By signing below, you authorize us to share medical information with the family/friend listed above and agree to abide by the policies described above. Further, all information you have provided is accurate to the best of your knowledge. If you wish to revoke this authorization, it must be done in writing.

Signature _____ Date _____

Relationship to patient (if not patient) _____

MEDICAL SERVICES AGREEMENT

Medical Consent: I consent to any treatments or procedures which may be performed on an outpatient basis (including emergency treatment or services), which may include but are not limited to medications, injections, taking of medical photographs, laboratory procedures, and/or x-ray examinations provided to me under the general and special instructions of the physicians, staff, or other health care providers of Sussex NP,LLC assisting my care.

Financial Agreement: I understand that all charges are due at the time of service. I agree to pay Sussex NP, LLC for all charges for healthcare services and professional services provided to me by physicians and other healthcare professionals. Acceptable forms of payment include Cash, Visa, MasterCard, Discover, and personal check. If I am a non-insured patient, I agree to pay for my visit in full at the time of service. If Sussex NP, LLC is a participating provider with my insurance company, I understand that my co-pay, coinsurance, deductible, and/or any outstanding balances are due at the time of service. I understand that my insurance policy is a contract between myself and my insurance company, Sussex NP, LLC is not involved. In order for Sussex NP, LLC to file claims and accept payments from my insurance carrier, I understand that I must present current insurance information at each visit and that Sussex NP, LLC will need to verify my health insurance coverage. In the event that Sussex NP, LLC is not able to verify my insurance eligibility and benefits before my visit, I agree to pay for my visit in full at the time of service. A refund will be issued if my insurance pays for the visit. I also understand that I am financially responsible for any services not covered by my insurance company. When my spouse or a financial guarantor signs this agreement, the spouse or the financial guarantor shall be jointly and individual liable with me. Should my account(s) be referred to an attorney or a collection agency for the collection, the undersigned shall pay the actual attorney's fees (including costs) and collections expenses incurred in addition to the other amounts due. Unpaid accounts referred to outside agencies for collection shall bear interest at the current rate per year from the date of referral**. A $10 billing fee is assessed every month in which a balance is carried over 30 days**. We understand extenuating circumstances, if you need to make payment arrangements, please contact the billing department. **There is a $35 fee for returned checks.**

Insurance Authorization and Release: I request the payment of authorized benefits, including Medicare, and any other government sponsored program, private insurance, and any other health plans to be made to Sussex NP, LLC for any services furnished by the provider. To the extent necessary to coordinate my health care or determine liability for payment and to obtain reimbursement for services rendered, I authorize Sussex NP, LLC to disclose portions of or all of my records, including my medical records to any person or corporation which is or may be liable for all or any portion of Sussex NP, LLC charges, including but not limited to insurance companies, health care service plans, governmental agencies, or worker's compensation carriers. I authorize Sussex NP, LLC to act as my agent to help me obtain any required pre-certification as well as acting as my agent to help me obtain payment from my insurance companies. I authorize my insurance companies to give Sussex NP, LLC any information required to fulfill this function. This will remain in effect until revoked in writing. A photocopy of this assignment and release is to be considered as valid as the original.

Release of Medical Information: I hereby authorize Sussex NP, LLC to release any information in my chart to any practitioner, doctor, hospital, or medical institution to which I may be referred to assist in

my care. Additionally, I authorize Sussex NP, LLC to provide a copy of my medical records to myself or any practitioner at my request.

Notice of Privacy Practices: By signing this form, you acknowledge receipt of the "Notice Of Privacy Practices" of Sussex NP, LLC. Our "Notice of Privacy Practices" provides information about how we may use and disclose your protected health information. We encourage you to read it in full. Our "Notice of Privacy Practices" is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting Sussex NP, LLC .

Personal Valuables: Sussex NP, LLC shall not be liable for the loss of or damage to any money, documents, jewelry, glasses, dentures, furs, or other articles of unusual value and shall not be liable for loss or damage to any personal property. Sussex NP, LLC, A medical corporation and the patient or the patient's representative, hereby enters into this agreement. The undersigned certifies that he/she has read and agree to the foregoing, and is the patient, the patient's representative or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

If you are more than 15 mins late to appointment you will be asked to reschedule, after 2 no call/no show's you will be discharged from practice. You must have at least 1 appointment a year to remained established patient.

Signature: _____Date: _____