Responsibility for Payment/Receipt of HIPAA Notice/Patient Communication

I understand that I am fully responsible for all fees due to Balance Health Family Health NP's, PLLC. or any associated medical provider (collectively referred to as the "Clinic") as a result of services I have received and that all fees are due and payable at the time of service unless Clinic agrees to accept assignment of my Medicare, Medicaid or other insurance benefits.

If I have insurance coverage other than Medicare:
I understand that assigning benefits to the Clinic and the filing of an insurance claim on my behalf is a courtesy to me and this is not absolving me of my responsibility to pay for services if the insurance company fails to pay for these services or if deductibles and/or co-pays are due. I understand that my insurance policy may not cover the full cost of services, or may consider it an uncovered service or medically unnecessary, or I may not have coverage benefits for these services. I therefore agree to be responsible for those charges incurred, as well as for my co-pay and/or any deductible that has not been met.

I further understand that any verification of my insurance benefits by the Clinic is not a guarantee of payment by my insurance company. If my insurance company does not pay for the services I have received, or fails to pay within 60 days of service, I understand that the Clinic will bill me for these services and I agree to pay any amounts due within 10 days of receipt of a bill for these services. In addition, if a claim is filed on my behalf as an unassigned claim, then I will also be responsible for the difference between the amount paid by my insurance company and the actual charge for that service.

If I am covered under Medicare or a Medicare Advantage health plan :
I understand that I will be responsible for my co-pay and/or any deductible that has not been met either through my Medicare coverage or any supplemental policy that I may also have. In addition, if a claim is filed on my behalf as an unassigned claim, then I will also be responsible for the difference between the amount paid by Medicare and the actual charge for that service.

I further understand that I will be notified in advance by an Advanced Beneficiary Notice of Noncoverage if Medicare likely will not pay for items or services. I will then have the right to make an informed choice whether or not to receive the items or services. If I choose to receive the items or services, I am aware that I will be responsible for paying for such items or services.

I request that payment of authorized Medicare, Medicaid or other insurance benefits be made on my behalf to the Clinic for any services furnished to me subject to any regulations pertaining to their assignment of benefits. I authorize any holder of my medical information to release to the Centers for Medicare & Medicaid Services, Social Security Administration and its agents, intermediaries or carriers, or to any other third-party sources or insurance companies and its agents any information or documentation needed to determine these benefits or the benefits payable for related services. A copy of this authorization may be used in place of an original and this authorization shall remain in force until revoked by me in writing.

I certify that the insurance information given by me is current and accurate to the best of my knowledge and I understand and agree to abide by the terms outlined above.

I further acknowledge that a copy of the Clinic's Notice of Privacy Practices has been made available to me.

I agree to receive appointment and treatment reminders via text and voicemail: ☐ YES ☐ NO

_____ _____
Patient Name (Please Print) Date Patient or Responsible Party Signature

_____ _____
Relationship to Patient Reason Patient Cannot Sign (if applicable)

Designation of Personal Representative

As required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), you have a right to nominate one or more persons to act on your behalf with respect to the protection of health information that pertains to you. By completing this form you are informing us of your wish to designate the named person(s) as your "personal representative." You may revoke this designation at any time by signing and dating the revocation section of your copy of this form and returning it to this office.

DESIGNATION SECTION:

I,_____ Date of Birth_____(print name and date of birth) hereby appoint the following person(s) to act as my personal representative(s) with respect to decisions involving the use and/or disclosure of health information that pertains to me.

PRINT Name of Personal Representative(s)	PRINT Relationship of each to Patient
_____	_____
_____	_____
_____	_____

The Authority of this person when serving as my "personal representative" is restricted to the following functions:

Description:

☐ This person is to be afforded all of the privileges that would be afforded to me with respect to my health information.

☐ This person is restricted to the following information about my health care:

_____

I understand that I may revoke this designation at any time by signing the revocation section of my copy of this form and returning it to: Balance Health Family Health NP's, PLLC.
50 Auert ave. Suite 3
Utica, NY 13502

I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this designation.

_____

Signature Date

REVOCATION SECTION:

I hereby revoke the designation of _____ as my personal representative.

_____

Patient Signature Date

Consent for Treatment

I, _____, am voluntarily seeking healthcare and hereby consent
(Patient's name)
to medical treatment, procedures, laboratory tests and other health care services. I understand that I have the right to refuse specific treatments or procedures. However, by signing below, I agree in general , to permit laboratory and diagnostic tests, routine medical treatment (for example, medications, injections, drawing blood for tests, counseling, screening tests, health education and other diagnostic procedures), emergency procedures as necessary, and hospital services performed at the request of the attending physician or other physicians assisting in my care.

The consent given shall be valid and binding and the providers can rely on this authorization and accept any consent given by the patient until such time as provider receives written notice that the authorization is revoked.

_____ _____

Patient Name (please print) Date of Birth

_____ _____

Signature of Patient or Legal Representative Relationship

_____

Date

Authorization for the Release of Protected Health Information (PHI)

Patient Name (Last, First, Middle): _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip code: _____

Contact Phone Number(s): _____

I hereby authorize the following entity to release the Protected Health Information (PHI) below to:

Balance Health Family Health NP', PLLC.
50 Auert ave. Suite 3 Utica, NY 13502
Telephone:315-316-0931 **Fax**

Entity Possessing the PHI: _____

Address: _____

City: _____ State: _____ Zip code: _____

Phone Number(s): _____ Fax: _____

If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated.

PHI and Dates of PHI Authorized for Use of Disclosure

Description	Start & End Date of PHI	Description	Start & End Date of PHI
[ ] All PHI Records	_____	[ ] History & Physical Exam	_____
[ ] Laboratory Test	_____	[ ] X-Ray Tests/Reports	_____
[ ] Progress Notes	_____	[ ] Discharge Summary	_____
[ ] Consultation Reports	_____	[ ] Itemized Billing Statement	_____

[ ] Other _____

****The following information will be released unless you indicate DO NOT RELEASE by checking the appropriate box**

[ ] AIDS/HIV OR STD treatment [ ] Psychiatric/Mental Care [ ] Alcohol/Drug/Substance Abuse [ ] Genetic Screening

Other, please specify: _____

I understand that:

- I may refuse to sign this authorization and it is strictly voluntary.
- My treatment, payment, enrollment of eligibility of benefits may not be conditioned on signing this authorization.
- I may revoke this authorization at any time in writing to the provider authorized to release the PHI, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
- If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by Federal Privacy Regulations and may be disclosed.
- I have the right to receive a COPY of this form after I sign it.
- I will receive a photocopy only of my medical record and that the original will remain with Primary Care Plus

Signature of Patient or Patient's Representative (if applicable): _____ Date: _____

Personal Representative's Relationship to Patient and Description of Authority to Act: _____