Compassionate Care
Leslie A. Smith, M.D.
400 Shadowline Drive
Suite 201B
Boone, NC 28607
Phone: 828-832-8300 Fax: 828-832-8303

HIPPA AUTHORIZATION FORM

(permissions from patient/patient's legal guardian to share personal medical information)

Patient Full Name: _____
Date of Birth: _____
Mailing Address: _____
City, State, Zip: _____
Email Address:_____
Emergency Contact: _____

I, _____, hereby authorize Compassionate Care (Dr. L. Smith) to release any and all medical information and test results that pertain to me to the following individual(s):

Name: _____ Phone #: _____Relationship _____
Name: _____ Phone #: _____Relationship _____
Name: _____ Phone #: _____Relationship _____
Name: _____ Phone #: _____Relationship _____
Name: _____ Phone #: _____Relationship _____

Is it okay to leave messages on your answering machine in the event that you do not answer your phone? _____ (Initial if yes)

I authorize Compassionate Care to contact the individual(s) listed above to convey any pertinent information about me in the event that I am unable to be reached. I understand that I may revoke/cancel this authorization or by notifying Compassionate Care in writing of my intent to revoke or change the name(s) of the individuals to whom information is to be released.

Signature of Patient or Legal Guardian: _____
Date: _____

Received by (Office use only): _____

Notice of Privacy Practices

Compassionate Care of North Carolina
Office of Dr. Leslie Smith
400 Shadowline Drive Suite 201B
Boone, NC 28607
Phone 828 832-8300 Fax 828 832 8303

Effective date: 6/12/2014

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. PLEASE REVIEW IT CAREFULLY.

If you have questions about this notice, contact Mr. Steve Kenyon, practice manager.

OUR OBLIGATIONS:

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for the treatment and services you recieved.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you that you have an appointment with us.

SPECIAL SITUATIONS:

As required by Law*:* We will disclose Health Information when required to do so by international, federal, state or local law.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obliged to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient is at risk for contracting or spreading a disease or condition ; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law.

Data Breach of Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or dispute, we may disclose Health Information in reponse to a court or administrative order.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similiar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's aggreement; (4) about a death we believe may be the result of criminal product; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right To Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment, and health care operations for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to Compassionate Care of North Carolina.

Right To Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. To request confidential communications, you must make your request, in writing, to Compassionate Care of North Carolina.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Informaion we already have as well any information we recieve in the future.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact us at the address above. All complaints must be made in writing. You will not be penalized for filing a complaint.

I have received a copy of this notice and have had my questions answered.

_____ _____

Patient or Legal Guardian Signature Date

Compassionate Care
FINANCIAL POLICY

We are doing everything possible to hold down the cost of medical care. You can help by reducing the number of bills we send to you. The following is a summary of our payment policy.

ALL PAYMENT IS EXPECTED AT TIME OF SERVICE

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance and copayments for participating insurance companies. Compassionate Care accepts cash, personal checks (in-state only), VISA, and MasterCard. There is a service charge of $30 for returned checks.

Patients with an outstanding balance 60 days or more overdue must make arrangements for payment prior to scheduling appointments. We realize that financial difficulty is a reality and we are here to work with you but you must keep us informed.

INSURANCE:
We bill participating insurance companies as a courtesy to you. You must bring a current insurance card for verification. If we cannot verify your insurance coverage, payment in full will be required at the time of your visit You are expected to pay your deductible and copayments at the time of service. If we have not received payment from your insurance company within 90 days of the date of service, you may be expected to pay the balance in full. You are responsible to be sure all charges are paid by you or by your insurance carrier.

If you need assistance or have questions, please contact the billing coordinator between 9am and 5pm Monday-Thursday at (828) 832-8300.

MANAGED CARE:
If you are enrolled in a managed care insurance plan (i.e., HMO) you must receive a referral from our office before seeing a specialist. Retroactive referrals are not guaranteed.

MISSED APPOINTMENTS/LATE CANCELLATIONS:
Broken appointment represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you. Cancellations are requested >24 hours prior to the appointment. A fee will be assessed for missed routine visits or if the appointment is cancelled <24 hours prior to the scheduled time at a rate of $20 for a routine visit and $50 for a complete physical exam. Excessive abuse or no shows of scheduled appointments may result in discharge from the practice.

I have read and understand Compassionate Care's Financial Policy. I agree to assign insurance benefits to Compassionate Care. I also agree that if it becomes necesssay to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections.

Signature of insured or authorized representative: _____
Date: _____

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Phone: 828-832-8300 Fax: 828-832-8303

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I HEREBY REQUEST A COPY OF THE FOLLOWING PATIENT'S MEDICAL RECORD:

Full Name of Patient: _____
Maiden Name/Alias: _____
Patient's DOB: _____ Patient's Phone Number: _____

Information Requested (X) ( ) Medical Record ( ) Psychiatric Records
******If only a portion of the Medical record or Psychiatric record is required please specify******

( ) Office Notes
( ) Discharge Summary ( ) History & Physical
( ) HIV Test/Status
( ) Emergency Room ( ) X-Ray Report
( ) Laboratory Records ( ) Progress Notes
( ) Radiology Film/Imaging/CD-ROM ( ) Other (Please Specify) _____

Date of service or date ranges requested including month and year: _____

The above record is to be released/mailed to the following individual:

( ) Compassionate Care of NC, P.A. (address above)

THIS RECORD IS REQUESTED FOR THE FOLLOWING REASON:
( ) Continued Medical Care ( ) Legal Purposes ( ) Insurance Purposes ( ) Personal Interest
This authorization must be signed and dated and may be revoked be notifying our office in writing at any time except to the extent action has been taken prior to revocation. This consent will expire 60 days after the date below or sooner by my choice.

I understand that the medical record released pursuant to this authorization could obtain information concerning drug related conditions, alcoholism, psychological conditions, psychiatric conditions, and/or blood borne infectious disease, which are subject to federal and/or state restrictions on disclosure. I understand that if the person or entity that receives information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protexted by these regulations. I hereby affirm that I have read and fully understood the above statements and consent to the disclosure of the medical record for the purpose and extent stated above.

Signature _____ **Date** _____

Patient, Parent or Legally authorized Representative