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Your Patient Privacy and Financial Policy

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected 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 available from the U.S. Department of Health and Human Services. 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 includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. You agree to the normal procedures utilized within the office for the handling 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, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. As the patient, you are responsible to provide your insurance information and update the office of any changes within 45 days, or your next appointment, whichever comes first. You are responsible for all copays and balances on your account.

4. You are responsible to notify the office of any cancellation 24 hours in advance. Any missed or cancelled appointments within 24 of scheduled time may result in a $25 fee per patient.

5. If timely payment is not made, it may become necessary to forward your account to a collection agency. As the patient, you agree to be held responsible for any fees charged by the collection agency for the cost of collections in addition to the amount owed.

I understand and agree with these notices.

Patient Name: _____ DOB:_____

Patient Name: _____ DOB:_____

Patient or Guardian Signature: _____ Date:_____