ConnectDCARE
FAMILY PRACTICE

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HIPAA Privacy - Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for **ConnectDCare Family Practice** to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO). (The Notice of Privacy Practices provided by **ConnectDCare Family Practice** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. **ConnectDCare Family Practice** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

CONNECTDCARE FAMILY PRACTICE
888 South State Street, Dover, DE 19901

With this consent, **ConnectDCare Family Practice** may: **(CALL)**
- Call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **ConnectDCare Family Practice** may: **(TEXT)**
- Text my provided cell phone number or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **ConnectDCare Family Practice** may: **(E-MAIL)**
- E-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **ConnectDCare Family Practice** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

With this consent, **ConnectDCare Family Practice** may: **(MAIL)**
- Mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements if they are marked “Personal and Confidential.”

By signing this form, I am consenting to allow **ConnectDCare Family Practice** to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **ConnectDCare Family Practice** may decline to provide treatment to me.

Financial Policies Agreement

Our clinic **DOES** accept insurance and Private Payments.

Patients are required to pay all costs incurred during each visit in-full on the same day as your visit. These may include visit fees, additional services, and prescriptions. We do not offer payment plans or issue outstanding balances.

Voluntary Termination of Care

ConnectDCare Family Practice or you (the patient) may suspend or terminate your care at any time.

Cancellation Policy

Thank you for choosing us as your health care provider. When you schedule an appointment with us, this appointment time is set aside especially for you and is not available to other patients. Therefore, it is important that you let your practitioner know as soon as possible if you will be unable to come to your scheduled appointment. This allows us to make this time available to other patients.

We request that you give at least 24 hours' notice if you need to cancel or reschedule your appointment. Please understand that if you do not provide adequate notice, you will be charged a $50 fee for the missed appointment.

Late Appointments

We do our very best to stay on schedule.
Late appointments are a challenge to maintaining a schedule. Arriving 15 minutes late may result in a cancelled appointment for which we will charge $50.00 fee. If you know you are going to be late, please let us know, and we will try our best to accommodate. I, the undersigned, have read and understand the above cancellation policy.

Communications

Our office confirms appointments the day prior to your appointment. Please indicate below, how would you prefer to receive confirmation?

Agreed Method of communication and appointment reminders, how may we contact you?

Phone / Email / Text / Mail

Signature: _____ Date: _____/_____/_____