VITTORIO M. MORREALE M.D., PLC 50505 Schoenherr Rd, Ste 200
NEUROSURGERY Shelby Township, MI 48315

ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

The patient or legally authorized representative of the patient, acknowledges that he or she has been offered Vittorio M. Morreale M.D., PLC's Notice of Privacy Policies on the date indicated below

_____ _____
Print name of Patient Relationship to Patient

_____ _____
Signature Date

PERMISSION TO GIVE MEDICAL INFORMATION

I, _____, herby authorize the physician and staff of Vittorio M. Morreale M.D., PLC to give information concerning my health and well-being to the following:

1._____ _____ _____
Name Relationship Phone

2._____ _____ _____
Name Relationship Phone

3._____ _____ _____
Name Relationship Phone

_____ I DO NOT authorize the release of my medical information to anyone.

Confidential messages may be left at the following
(Such as appointment reminders or medical information)

Home Cell Work

For legal Guardian, Personal Representative or person with authority under a durable power of attorney, a copy of appropriate documentation may be necessary.

PRIVACY POLICY

We may deny your request for an amendment if it is not in writing or does not include a reason for the request. We may also deny your request if you ask us to amend information that:

- was not created by our practice;
- is not part of the healthcare information maintained by the practice;
- is accurate or complete

Right to an Accounting of Disclosures – You have the right to request a restriction or limitation on the information we use or disclose about you for treatment, operations or payment. You also have the right to request a restriction or limitation on the information we use to disclose about you to someone who is involved in your care, or payment for your care, like a friend or family member. For example, you may request that we do not disclose information about the results of a certain diagnostic tests.

We may deny your request for a restriction if it is not in writing, does not include a reason for the request, or if we have no reasonable means to ensure that your request can be honored. An example of a reason to deny a restriction would include, but not necessary be limited to, a request by you not to forward healthcare information to a public health agency if you have a communicable disease that we are required by law to report.

Right to File a Complaint – You have the right to file a complaint if you think your privacy rights have been violated. You may file a complaint with us, or with the Secretary of the Department of Health and Human Services in Washington, D.C. To file a complaint with us please contact our Privacy Officer at the practice. All complaints must be submitted in writing. We will make every effort to resolve your complaint in a timely and accurate manner. YOU WILL NOT BE PENALIZED IN ANY WAY FOR FILING A COMPLAINT.

NOTICE OF ACKNOWLEDGEMENT

You have the right to a paper copy of this notice. We reserve the right to change this notice.

I acknowledge that I have received the attached Notice of Privacy Practice:

_____ _____

Patient **or** Personal Representative Signature Date

OUR PRACTICE FINANCIAL POLICY

We are dedicated to provide you with the best possible care and service, and regard your understanding of our financial policies as an essential element of your care and treatment. To assist you, we have developed the following financial policy. If you have any questions, please feel free to discuss them with our staff.
Unless other arrangements have been made in advance by either yourself or your health coverage carrier, full payment is due at the time of service.

YOUR INSURANCE

We have made prior arrangements with many insures and other health plans. We will bill those plans with whom we have an agreement and will collect any required copayment at the time of service. The copayment will be collected when you arrive for your appointment. In the event your health plan determines a service to be "not covered," you will be responsible for the complete charges and be asked to pay at the time of service.

If you have insurance coverage with a plan with which we **do not** have a prior agreement, we will prepare and send the claim for you, on an unassigned basis. In this case, you will be responsible for the difference between the actual doctor's charge and what your insurance carrier pays, **such as any out of network penalty.**

We will also bill your health plan for all services we provide in the hospital. Any balance is your responsibility and is due upon receipt of a statement from our billing service.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

_____ _____

Signature of Patient **OR** Responsible Party Date

_____

Print Name of Patient