HIPAA Act of 1996

Notice of Patient Privacy Practices

This notice describes how medical information about the patient may be used, disclosed and how to gain access to this information. Please review carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires all medical information and individually identifiable health information used or disclosed by us in any form, electronic, paper or orally are kept properly confidential. This Act gives you, the patient significant new rights to understand and control how your health information is used. *We may use and disclose your records for each of the following purposes: Treatment, Payment and Health care Operations (Definitions are available upon request) Detailed HIPAA, Medicare standards and Patient's Rights are found at www.solutionsorthocare.com)*

We may contact you about supply alternatives, other health related benefits and services that may be of interest. We may disclose medical information to family members or caregivers. We may disclose medical information when required to do so by federal, state or local law or to an oversight agency for activities authorized by law.

Any other uses or disclosures will be made only with your written authorization. You may revoke such authorization and we are required to honor and abide by that written consent. You have rights with respects to your Protected Health Information. We are required by law to maintain the privacy of your protected health information and provide to you with notice of our legal duties and privacy practices with respects to protected health information. We will notify you in the case of any breach of your Protected Health Information.

This notice takes effect immediately and we are required to abide to the terms of this privacy notice. You have recourse if you feel your privacy protections have been violated. You have the right to file a written complaint with our office or the Department of Health and Human Services.

I, _____ have read and acknowledged the above HIPAA Privacy Act of 1996 statement
(SIGNATURE) and have received a copy of the web link and/or hard copy of the Foot Solutions HIPAA Notice of Privacy Practices for Personal Health Information. I authorize my physician to share medical information with Solutions Orthocare Group.

Date: _____

AUTHORIZATION OF BILLING

I, _____ authorize the use of my insurance information to **bill** for *SERVICES RENDERED or TO BE RENDERED VIA PRIOR AUTHORIZATIONS, PRE-DETERMINATIONS & RE-DETERMINATIONS.* I understand that my insurance(s) may decide to not pay for stated services. I agree to be held responsible for services and/or covered items submitted to my primary insurance and/or secondary insurance with adequate documentation. I understand that a claim will be submitted to my primary insurance and/or secondary insurance on my behalf and payment assignment will be accepted by Solutions Orthocare Group, LLC. Any co-payments or deductibles due after payment has been made are my responsibility unless other arrangements have made at time of delivery.

I, _____ *have read and acknowledged the above authorization of billing. Date:* _____
(SIGNATURE)