



PATIENT CONSENT AND CHARGE INFORMATION

The Department of Health and Human Services has established a “Privacy Rule” to help ensure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients’ consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and we will do all we can to protect your privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those in need of your health information and information about your treatment, payment, and health care operations, in order to provide health care that is in your best interest.

We also want you to know we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for the purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you refuse to disclose your personal health information. If you choose to give consent at some future time you may request to refuse all or part of your personal health information. You may not revoke actions that have all ready been taken.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our policy notice, to request restrictions, and revoke consent in writing after you have reviewed our privacy policy.

I also understand I am responsible for all charges, regardless of insurance coverage. I agree to pay charges in accordance with regular rates and payment terms of the clinic. In addition, if my account is referred for collection, I agree to pay all collection expenses, including attorney fees. I assign benefits from insurance to cover cost of treatment provided by this clinic.

Medicare patients: If Medicare does not pay for all services provided, I will be responsible for any additional charges.



PATIENT INFORMATION
(Please Print)

RESPONSIBLE PARTY / PARENT INFORMATION

Name (First, Middle, Last) **M / F**

Name (IF MINOR) **M / F**

Mailing Address

Date of Birth

City State Zip

Social Security Number

Date of Birth

Employer

Social Security Number

Work Phone

Home Phone

Cell Phone

Email Address

IN CASE OF EMERGENCY

PRIMARY CARE PHYSICIAN

Name

Physician's Name

Phone Number

Phone Number

Relationship

PRIMARY INSURANCE HOLDER

SECONDARY INSURANCE HOLDER

Policy Holders Name (First, Last) **M / F**

Policy Holders Name (First, Last) **M / F**

Mailing Address

Mailing Address

City State Zip

City State Zip

Date of Birth

Date of Birth

Social Security Number

Social Security Number

Relationship to Patient

Relationship to Patient

Employer Name Phone

Employer Name Phone

I HAVE READ THE BILLING AND HIPAA PRIVACY INFORMATION (FIRST PAGE of FORM)

X _____ **DATE** _____
PATIENT SIGNATURE (PARENT IF A MINOR)