Harrisonburg Foot & Ankle Clinic, PC

HIPAA Compliance Assurance Notification

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation and money. It is our policy to properly determine appropriate uses of personal health information. We strive to achieve the very highest standards of ethics and integrity in performing services for our patients. We continually undergo training so that we understand and comply with government rules and regulations regarding the Health Information Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule". We also know that we are not perfect and because of this fact, our policy is to listen to our patients if they feel an event in any way compromises our policy of integrity. We welcome your input regarding any issues so that we may address the situation promptly.

** Treatment Authorization **

The Patient and/or the Patient's responsible decision maker consent to any and all examinations and treatments directed by the physician and rendered by the staff.

** Release of Information, Assignment of Benefits and Payments **

Release of Information:

I authorize my healthcare provider to release and exchange information with other healthcare providers, insurance companies, collection agencies, courts, etc…, to provide continuity of care, to secure payment, or to meet requests relative to medical or financial necessity. I understand that I have the right to request restrictions on how my health information is used and disclosed, but my healthcare provider is not required by law to agree to these requested restrictions. My healthcare provider also reserves the right to change the terms of this notice, at which time I will be asked to review and sign the amended version.

Assignment of Insurance Benefits:

I assign any and all health insurance benefits to be paid directly to my healthcare provider for services rendered.

Responsibility for Payment of Bill:

I understand that I, or the person listed as guarantor, remain financially responsible to my healthcare provider for any and all charges not covered by my health insurance or not paid by my health insurance company within a reasonable amount of time. I also understand I am responsible for co-payments, deductibles and all other charges for services not covered by my health insurance company. I authorize providers to pursue a 25% collection fee of all unpaid debt, directly or through a collection agency. I agree to pay all costs associated with such collection, including attorney fees incurred.

** Billing Consent and Acknowledgment of Privacy Practices Notice **

I have read and understand this form and any questions that I had, were explained to my satisfaction. I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under the Health Information Portability and Accountability Act (HIPAA).

_____ _____

Signature of Patient/Guardian Date

HARRISONBURG FOOT & ANKLE CLINIC, PC

PATIENT INFORMATION: Date: _____

Name: _____ Marital Status: S M W D
Last First MI

Address: _____City: _____State: _____Zip:_____

Social Security #: _____ Home Phone #: _____

Cell Phone #: _____ Date of Birth: _____ Age: _____

Employer: _____Occupation: _____ Work #: _____

Email Address :_____

****

INSURANCE INFORMATION:

Name of Primary Insurance: _____ Policy Holder's Relationship to Patient: Self Spouse Parent

Name of Policy Holder:_____Date of Birth:_____
Last First MI

Name of Secondary Insurance: _____ Policy Holder's Relationship to Patient: Self Spouse Parent

Name of Policy Holder:_____Date of Birth:_____
Last First MI

****

BILLING INFORMATION: Relationship to Patient: Self Spouse Parent

Name of Person Responsible for Payment: _____
Last First MI

Address: _____City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ Social Security #: _____

****

OTHER INFORMATION:

With whom may we discuss your medical / financial information? (spouse, mother, father, POA, etc.)

Name: _____Relationship: _____ Phone #: _____

Name: _____ Relationship: _____Phone #: _____

Who referred you to our office or how did you hear about us? _____

Who is your primary care physician? _____

Address or general location: _____

Please read and sign back page.