TO OUR PATIENT

IMPORTANT PRIVACY POLICY

At our office we value you as a patient and share your concerns about privacy. To help you understand how we treat the nonpublic personal information (patient information) that we obtain from you or other sources in the course of providing you care, this notice describes our use and protection of that information.

OUR OFFICE POLICY

- We do not sell patient information.
- We do not share your information with persons, companies, or organizations outside of our office that would use that information to contact you.
- We expect persons and organizations that provide services on our behalf to keep patient information confidential and to use it only to provide the services we have asked them to perform.
- Within our office, we communicate to our employees regarding the need to protect patient information, and we've established physical, electronic, and procedural safeguards to protect patient information.

Below we have provide answers to questions that might be on your mind regarding privacy. You may be wondering...

What do we do with your patient information?

Our office does not sell your patient medical information to anyone. Nor do we share it with companies or organizations outside our office that would use that information to contact you. If that practice were ever to change, we, of course, offer you the ability to opt-out of this type of information sharing, (opt-infor medical information) with time for you to respond before the change in our practice took place.

We may, without authorization but only as permitted or required by law, provide patient information to persons or organizations to fulfill a transaction you have requested. Investigate and/or handle claims, detect and/or prevent fraud, participate in insurance support organizations, or comply with lawful requests from regulatory and law enforcement authorities.

What kind of patient information do we have, and where did we get it?

Much of the information that we have about you comes directly from you. When submitted your request for medical records you may give us information such as your name, address, and social security number. We may contact you by telephone or mail for additional information we keep information about your visit, lab, x-rays, and medical tests, with us.

How can you find out what information we have about you?

You may request to see the information about you in our records that is not otherwise restricted from disclosure. If you believe that information is incomplete or inaccurate, you may request that we make any necessary corrections, additions or deletions to the disputed information.

FINANCIAL AUTHORIZATION

I authorize the retease of any previous results or images in the event it is needed to help with the diagnosis and plan of care for further treatment, I permit a copy of this authorization to be used in place of the original. I understand and acknowledge that I am personally responsible for the services rendered at this facility. We will bill your insurance earner as a courtesy. In the even! of non-payment, I understand I will be responsible for any outstanding balances.

NO CALL NO SHOW POLICY

Beginning January 1, 2011 we enacted a "NO CALL NO SHOW" policy whereby patients who do not cancel or change their scheduled appointmenttime within a 24 hour time line will be billed a minimum of $25.00. We regret the need to enforce this policy, however appointments that are missed resultin a delayed service forothers. Please sign below to acknowledge your understanding and receipt of this notification. We thank you for your patronage and look forward to providing you the exceptional care you've come to expect from our office.

CONSENT TO CALL

By selecting I accept below, the patient is giving permission for the practice to use the information provided as part of the check in process to email and call the patient. This includes: Entry of any telephone contact number constitutes written consent to receive any automated, prerecorded, and artificial voice telephone calls initiated by the Practice. To alter or revoke this consent, visit the Patient Portal “Contact Preferences".

Consent to Text

Consent to Text indicates whether the patient has agreed to receive automated text alerts from the practice on their mobile phone. Text alerts may be about appointments, test results, and more.

Select "I accept" if the patient has agreed to receive automated text alerts. Select "I decline" if the patient has declined.

Formulary Benefits Data Consent Form

Formulary Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Manager (PBM). PBM's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

By signing below, I give permission for the practice to access my pharmacy benefits data, electronically through RxHub. This consent will enable the practice to:

- Determine the pharmacy benefits and drug co-pays for my health plan
- Check whether a prescribed medication is covered (in formulary) under my plan
- Display therapeutic alternatives with preference rank (if available) within a drug class for non-formulary medications
- Determine if my health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies
- Download a historic list of all medications prescribed for me by any provider

Release of Information Authorization

PATIENT CONSENT FORM

My Notice of Privacy Practices provides information about how I may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review this Notice before signing this Consent The terms of this Notice may change. If I change this Notice, you may obtain a revised copy by contacting our office.

You have the right to request that I restrict how protected health information about you is used or disclosed for treatment payment or health care operations. I am not required to agree to this restriction, but if I do, I shall honor that agreement.
By signing this form, you consent to my use and disclosure of protected health information about you for treatment payment, and health care operations. You have the right to revoke this Consent in writing, signed by you. However, such a revocation shall not affect any disclosures I have already made in reliance on your prior Consent The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:
Protected health information may be disclosed or used for treatment, payment or health care operations.
The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
The Practice reserves the right to change the Notice of Privacy Policies.
The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
The Practice may condition treatment upon the execution of this Consent

Privacy Options

${CheckboxReleaseNo} I want NO ONE to receive my personal health information**.**

${CheckboxReleaseYes} The names listed below are authorized to access my Protected Health Information:

${ReleaseOneName}	${ReleaseOneRelationship}	${ReleaseOneNumber}
${ReleaseTwoName}	${ReleaseRelationship}	${ReleaseTwoNumber}
${ReleaseThreeName}	${ReleaseThreeRelationship}	${ReleaseThreeNumber}