HIPAA / Notice of Privacy Practices / Consent for Diagnosis and Treatment

Patient Name: _____
Date of Birth:_____
Primary Care Provider: _____

I agree that medical information may be left on my answering machine or voicemail:
Yes ❒ No ❒
I agree that this person can call on my behalf and medical information may be given to:

Name: _____ Phone: _____ Relationship: _____

Name:_____ Phone: _____ Relationship: _____

Name:_____ Phone: _____ Relationship: _____

Name:_____ Phone: _____ Relationship: _____

Name:_____ Phone: _____ Relationship: _____

Initials: _____

As a courtesy to our patients we will file a claim with the primary insurance on your behalf. All charges regardless of the insurance coverage are the patient's responsibility. We ask that if your insurance company has not paid within 45 days that you contact them. Any questions regarding your benefit coverage should be directed to your insurance company prior to coming in for your appointment. We will make a copy of the insurance card for billing purposes and we will collect your copay at every visit.

I hereby authorize Frenchtown Medical and Wellness to supply information to the insurance carrier(s) regarding my illness and treatment with respect to the services rendered and I assign all payments for such services to Frenchtown Family Medical and Wellness. I understand that I am financially responsible for all charges.

I have read and understand the contents of this disclosure and certify that this information is true and accurate and I agree to the terms of this disclosure.

Signature: _____
Date: _____/_____/_____

This document is valid for 3 Years

Phone Consent; I consent to and authorize Frenchtown Family Medical and Wellness to contact me via phone or text in relation to any services received or planned to be received including billing items and appointment reminders.
PHI: I authorize Frenchtown Family Medical and Wellness to use and disclose my protected health information to perform, treatment, payment and health care operations. The practice may call or mail to my home or alternative location and leave voicemail or email referencing any items to perform treatment, payment and health care operations such as insurance items, laboratory tests or items pertaining to clinical care. I may revoke consent in writing except to the extent the practice has already made disclosures with my prior consent. If I do not sign this consent or later revoke it the practice may decline to provide me treatment.
Initial Here: _____

Medication History: A variety of sources including pharmacies and health insurers contribute to the collection of your medication history. It is stored in the clinic's electronic medical record system and becomes part of your personal record. Medication history is important in helping providers treat symptoms properly to avoid dangerous drug interactions. It is important that you and your provider discuss all your medications in order to ensure your medication history is 100% accurate. I give permission to allow my healthcare provider to obtain my medication history from pharmacies, health plans and providers.
Initial Here: _____

I give permission to Frenchtown Medical and Wellness to give me medical treatment and to bill my insurance to pay for the care I receive. I understand the practice will have to send my medical information to the insurance company and I must pay my share of the costs. I must pay for services if my insurance company does not pay. I have the right to refuse any procedure or treatment. I have the right to discuss all medical treatments with my provider. I am financially responsible for all charges incurred regardless of insurance coverage or third-party liability and all proceeds of insurance are assigned to this office. I authorize the practice to release medical information necessary to process claims. There will be a finance charge of 10% for any unpaid balance over 90 days and I will be charged an additional fee (50% of unpaid balance) if my debt is assigned to a collection agency. This amount shall be in addition to any other costs incurred directly or indirectly to collect the amount owed.
I also acknowledge that I have received a copy of the Patient Financial Policy
Initial Here: _____

I understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examinations and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this serves as a basis for planning care and treatment, communicating with health professionals who may contribute to my care, a source of information for applying for diagnosis and surgical information to my bill, a means by which a third party can verify services billed were services rendered and a tool for routing health care operations such as assessing quality and reviewing the competence of health care professionals. I understand as part of my care and treatment it may be necessary to provide my protected health information as specified below for the purpose and to the parties designated to me:

This practice reserves the right to change the notices and practices and that prior to implementation, will mail a copy of any notice to the address I provided if requested. I have the right to to reject the use of my health information for directory purposes.

I may Revoke this consent in writing at any time except to the extent that this practice has already taken action in reliance thereon.

I have a right to request restrictions as to how my PHI may be used or disclosed and this practice is not required by law to agree to the restrictions requested.

Initial Here:_____ Printed Patient Name:_____

Signature:_____ Date:____/____/____

Valid For Three Years