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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth ____/____/____

Medical Record#: _____

___ By signing this form, I authorize Family Clinic of Ville Platte to use/disclose the following information/medical records to.

___ By signing this form, I give permission for the provider listed below to release the following information to Family Clinic of Ville Platte:

Name of Recipient/Facility: _____

Address: _____

Phone: _____

Fax: _____

___ Please send entire medical record to the above named recipient.

___ Office Notes

___ Medication Records

___ Billing Records

___ Immunization Records

Other specified records: _____

Date of Service: _____ Purpose of Request: _____

DRUG/ALCOHOL ABUSE, PSYCHIATRIC, HIV/AIDS RECORDS RELEASE

I understand if my medical or billing records contain information in reference to drug/alcohol abuse, psychiatric, HIV/AIDS, I agree to its release: Check one: ___ Yes ___ No

REDISCLASURE:

I understand that if the person or entity receiving the information is not a health care provider or health plan protected by these regulations. Family Clinic of Ville Platte and its employees are hereby released from any legal responsibility for the disclosure of the above information to the extent indicated and authorized herein.

TIME LIMIT AND RIGHT TO REVOKE:

Except to the extent that action has already been taken in reliance on the authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer, unless revoked, this authorization will expire on this specified date or event: _____.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE:

I understand that I do not have to sign this authorization and my treatment or payment for services will not be denied if I do not sign this form; that I may review the information described above and request a copy of this form after I sign it:

SIGNATURE: _____ DATE: _____

Relationship to Patient: _____ Witness: _____

Financial Policy

PATIENT RESPONSIBILITY FOR FEES

We require that our patients promptly pay all charges that we present to them. In some cases, our fees may be adjusted, based on whether we participate in or accept insurance or government program payments, allowances, or limitations. But, if we present a charge to you, it means that we have taken any such adjustment into account and that you must still pay the amount remaining. If you are reimbursed directly by an insurance company for the cost of your care, you must still pay our charges promptly, whether or not you have received that reimbursement.

If you do not agree with patient responsibility amounts or reimbursement amounts set by your insurance company, this is a matter between you and that company. We are happy to provide you with factual information about your care and billing to help you discuss this with them, but we still require you to promptly pay the entire charge we present to you, even if the issue with the company is not resolved.

Payment for your services is due PRIOR TO services being provided to you. This includes, among other things, copay amounts, deductibles, earlier charges that remain unpaid, and charges for services that we believe are not covered by , or are left over at you responsibility to pay after coverage by insurance company. We or our agents may send you statements and reminders of charges made and amounts that we believe must be paid, or may call you about the same. We expected these charges to be paid promptly as well. By accepting our services, you are consenting to receive these communications. It is your responsibility to provide our office with current phone numbers, mailing address and email address. Once we have generated four statements for unpaid balances with no payment that account will be turned over to collections, even if it is due to inaccurate account information.

We accept cash, check and all major credit cards for account payments.

Initial: _____

Date: _____

PRIVACY PRACTICES/ ASSIGNMENT OF BENEFITS

Continued

ASSIGNMENT OF BENEFITS

I hereby assign to The Family Clinic of Ville Platte any insurance or other third-party benefits available for healthcare services provided to me. I understand that Family Clinic of Ville Platte has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Family Clinic of Ville Platte, I agree to forward to Family Clinic of Ville Platte all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt.

CONSENT FOR CLINICAL SERVICES

I hereby give my consent to Family Clinic of Ville Platte to solicit medical and personal history from me and maintain information as part of my personal file in the clinic. As a patient, I will accept all tests, examinations and prescriptions and accept to be treated by an Advanced Practice Registered Nurse. I understand that all information in my file will be kept confidential and will not be given to any person/agency within the off of Family Clinic of Ville Platte without prior approval by me.

I hereby consent to the following treatment after discussion with the medical provider:

Administration and performance of all treatments

Administration of any needed anesthetics

Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient

Use of prescribed medication

Performance of diagnostic procedures, tests and cultures

Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending Nurse Practitioner, Physician or other assigned designees.

Initial: _____

Date: _____

PATIENT RIGHTS AND RESPONSIBILITIES

Patients of Family Clinic of Ville Platte shall have the right to:

- Quality services, appropriate to their care needs which are delivered in a timely manner
- Be treated equally and receive care without regard to age, sex religion, race or creed
- Confidentiality of his/her clinical records
- Be informed of all costs and expected payment from other resources
- Be treated with respect for individual patient's comfort, dignity, and privacy
- Be informed of his/her rights in advance of care being provided
- Obtain, from the practitioner, complete and current information concerning his/her diagnosis (to degree known, treatment, and any known prognosis)
- To inspect your medical records upon request, and to receive a copy for a reasonable fee
- Refuse treatment to the extent permitted by law

Patients of Family Clinic of Ville Platte are responsible for:

- To give your health care provider correct and complete information about your present medical condition, chief complaint, past illnesses, hospitalizations, medications, including over-the-counter drugs/herbal supplements, and other health matters- including drugs, alcohol, smoking and eating habits
- To provide your healthcare provider with accurate and updated demographic information such as address and phone numbers
- To follow the treatment plan and advice recommended by your health care provider
- To accept responsibility for your actions and decisions if you refuse treatment (or portions of recommended treatment) or do not follow the health care provider's complete instructions
- To meet your health care financial obligations promptly, including fees, co-pays, and deductibles
- To be considerate of the health care provider's other patients, personnel and property, and to treat them with respect and courtesy, as you would prefer to be treated
- To notify your PCP when you receive emergency care within twenty-four (24) hours, or as soon as possible

Initial: _____

Date: _____

ACKNOWLEDGEMENT OF RECEIPT

Name of Patient (Print)

I acknowledge that I have been given the Family Clinic of Ville Platte Notice of Privacy Practices/Assignment of Benefits. I Certify that I have read and fully understand the statements in the policy and consent fully and voluntarily. This consent will remain in force until revoked in writing.

I acknowledge that I have been given the Family Clinic of Ville Platte Financial Policy, and I will be financially responsible for the above Mentioned patient.

I acknowledge that I have been given the Family Clinic of Ville Platte Patient Rights and Responsibility Policy.

Signature of Patient

Date

Signature of Patient Representative

Relationship to Patient

I would like copies of this paperwork at this time YES NO

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

LAYERED SUMMARY TEXT –

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Market our services
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home, mobile or office phone) or to send mail to a different address. You may receive artificial, prerecorded, or automated calls and text messages, including Athena Communicator communications unless you specify otherwise.
- We will say “yes” to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A Doctor/Nurse Practitioner treating you for an injury asks another Doctor/Nurse Practitioner about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications

- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Other Instructions for Notice

- September 1, 2013
- Family Clinic of Ville Platte
tfcovp@gmail.com
337.363.3180
- “we never market or sell personal information.”
- “We will never share any substance abuse treatment records without your written permission.”
- Log on to the Patient Portal at www.battsfamilypractitioners.com/patient-portal.html
- Log on to the Website for Forms www.battsfamilypractitioners.com/patient-forms.html