HIPAA Privacy Rule Receipt of Notice of Privacy Practices Written Acknowledgement Form

Family Urgent Care Industrial Medical Clinic, Inc.

Acknowledgement of receipt of Information Practices Notice (§164.520(a))

I,_____ (Patient's Name) understand that as part of my health care, Family Urgent Care Industrial Medical Clinic, Inc. originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that Family Urgent Care Industrial Medical Clinic, Inc. **Notice of Privacy Practices** provides a complete description *of* the uses and disclosures of my health information. I understand that:

- I have the right to review Family Urgent Care Industrial Medical Clinic, Inc. Notice *of* Privacy Practices prior to signing this acknowledgement;
- that Family Urgent Care Industrial Medical Clinic, Inc. reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.

Signature *of* Individual or Legal Representative Witness .....

Printed Name of Individual or Legal Representative Witness.....

Date: .....

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barrier prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Others (please specify)

_____

_____

_____ _____

Annel Lupian
Privacy Official

Date

HIPAA Privacy Rule of Patient Authorization Agreement

Family Urgent Care Industrial Medical Clinic, Inc.

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I, _____ (Patient's Name) understand that as part of my health care, Family Urgent Care Industrial Medical Clinic, Inc., originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my health care;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals

I have been provided with a copy of the ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review Family Urgent Care Industrial Medical Clinic, Inc. notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review Family Urgent Care Industrial Medical Clinic, Inc. Notice of Information practices prior to signing this consent;
- That Family Urgent Care Industrial Medical Clinic, Inc., reserves the right to change the notice and practices and that prior to implementation will mail a copy of any revised notice to the address I've provided if requested;
- I have the right to object to the use of my health information for directory purposes;
- I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Family Urgent Care Industrial Medical Clinic, Inc., is not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at any time, except to the extent that Family Urgent Care Industrial Medical Clinic, Inc., has already taken action in reliance thereon.

Signature of Patient or Legal Representative Witness .....

Printed Name of Patient or Legal Representative Witness .....

Date: .....

F. ILY URGENT CARE
A Professional Corporation

PATIENT INFORMATION

Last Name | First Name | Middle Name | Social Security Number

Birthdate | Age | Sex | Marital Status | Height | Weight

Address | Street | Apt # | City | State | Zip Code

Home Telephone | I.D. or Driver's Lic. # | Name of Guarantor if Minor

E-Mail:

Parent Social Security Number & Date of birth (If Minor)

PATIENT EMPLOYED BY:

Employer Name | Occupation | Work Telephone

Address | Street | City | State | Zip Code

INSURANCE INFORMATION:

Insurance Name | Telephone

Address | Street | City | State | Zip Code

Policy # | Group # | Cert. #

Name of Insured | Date of birth | Relationship to Patient

Work Related Injury | yes | No | Date of Injury

Employer Name at the Time of Injury | Telephone

Address | Street | City | State | Zip Code

REASON FOR VISIT

MEDICAL CONDITION

List any kind of allergies

Describe any Medical Condition

List all Medication you are taking

PAYMENT AUTHORIZATION:

I hereby authorize Family Urgent Care to furnish the necessary information for billing purposes. I direct the insurer to pay, directly to the physician, all benefits due to him as a result of this claim. Although covered by insurance, I am aware that I am responsible for all charges, including the balance remaining after payment of possible insurance A copy of this authorization will be as valid as the original to release any information necessary to process this claim.

Signature of Patient | Date

Authorization for Minors | Date

DATE :_____

DR :_____

FINANCIAL RESPONSIBILITY

THIS IS TO VERIFY THAT THE PATIENT UNDERSTANDS THE TERMS INVOLVED BY USING THE OUT OF NETWORK POS/ PPO WITH THEIR INSURANCE. WHEN SEEING OUR DOCTORS YOU WILL BE USING THIS OPTION AND WILL ACCEPT THE FINANCIAL RESPONSIBILITY FOR PAYMENT OF ANY BALANCE THAT YOUR INSURANCE DETERMINES TO BE THE SUBSCRIBER DEDUCTIBLE AND OR CO-INSURANCE LIABILITY.

_____

PATIENT'S SIGNATURE

_____

WITNESS