

VALLEY GASTROENTEROLOGY & ENDOSCOPY

HIPPA POLICY

Patient Name: _____

Account #: _____

Date of Birth: _____

SSN: _____

I give permission to be contacted in the following manner (please check all that apply):

- ☐ Home telephone: _____ ☐ Work telephone: _____
- ☐ Written communication to home/work office ☐ Ok to leave a message with information home/work
- ☐ Leave message with call-back number ONLY-home ☐ Leave message with call-back number ONLY-work
- ☐ Ok to leave a message at home with the following family members: _____

Person (s) allowed to receive your medical information:

_____ Relationship: _____ Phone: _____

_____ Relationship: _____ Phone: _____

I CONSENT TO CARE AND TREATMENT

I consent to examination, treatment, and testing by my attending physician, facility personnel or authorized agents who may be involved in my care.

I CONSENT TO USE/DISCLOSURE OF MY MEDICAL INFORMATION

I authorize the use and disclosure of my medical information, including information relating to AIDS and the results of HIV-testing; drug or substance abuse; and mental health related treatment and services for the purpose of treatment, payment and/or healthcare operations.

I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES

I have received my provider's Notice of Privacy Practices, which tells how my health information may be used and shared. I understand that my provider reserves the right to revise the notice at any time, and that I can always get the current copy by asking for it.

INSURANCE PAYMENTS DIRECTLY TO THE FACILITY

I authorize my provider or any facility providing services to me to directly bill and collect payment from my insurance company, Medicare, Medicaid, or other company that pays my medical bills. I understand that I may receive a separate bill for radiology or laboratory services provided by another facility. I certify that all information given by me in applying for payment by any third party is true and accurate.

I AGREE TO PAY FOR THE COST OF CARE AND TREATMENT AT TIME OF SERVICE

I accept responsibility for the cost of all services provided to me. I understand that I may have to pay charges that are not paid by my insurance company or anyone else. I will pay the collection costs, including court costs; if legal action must be taken to collect my unpaid bill.

RESPONSIBLE PARTY SIGNATURE

DATE