CliniCare ID Consultants of CSRA

PRIVACY POLICY ACKNOWLEDGEMENT STATEMENT

I hereby acknowledge that I have been made aware that CliniCare ID Consultants of CSRA has a Privacy Policy in place in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and has been revised in accordance with the new HIPAA guidelines in effect as of September 2013.

CliniCare ID Consultants of CSRA has made this policy available to me for review by placing a complete version in a binder that resides in the waiting room and/or by placing a poster version of this policy in the waiting room or similar common area with patient access.

I am aware that as a patient I am entitled to a copy of this Privacy Policy if I desire a copy for my personal file.

⇨ _____ _____

Patient Signature or Authorized Person/Parent/Guardian Date

MEDICARE PATIENTS

I understand and acknowledge under Medicare law, I must pay a $147.00 annual deductible for Part B services and a 20% co-payment/co-insurance on claims for services that are submitted after meeting the deductible.

⇨ _____ _____

Patient Signature or Authorized Person/Parent/Guardian Date

CANCELLATION POLICY

I understand it is my responsibility to cancel or reschedule an appointment 24 hours prior to, and that if I fail to do so, I may be assessed a cancellation fee of $75. I understand that this fee is not covered by my insurance plan.

⇨ _____ _____

Patient Signature or Authorized Person/Parent/Guardian Date

CliniCare ID Consultants of CSRA has a secure server and encryption for email communication. However, we cannot guarantee encryption on the recipient end and cannot be held liable for such. By signing below you are giving CliniCare permission to send your PHI via email. I understand that insurance will be filed by this office as a courtesy and does not constitute a contract between the physician and insurance company for payment of services.

I UNDERSTAND CO-PAYS, DEDUCTIBLES AND ANY OTHER PATIENT RESPONSIBILITY FEES ARE DUE WHEN SERVICES ARE RENDERED.

⇨ _____ _____

Patient Signature or Authorized Person/Parent/Guardian Date

I hereby authorize *CliniCare ID Consultants of CSRA* to furnish to my insurance company or to the social security administration and health care financing or its intermediates or carrier any information needed regarding my medical treatment. Regulations pertaining to Medicare assignment of benefits apply. I also authorize my insurance benefits to be paid directly to CliniCare ID Consultants of CSRA. I understand that I am financially responsible for all services rendered including charges or penalties made to *CliniCare ID Consultants of CSRA* for any outside collection assistance. I realize that the physician is not responsible for any financial decisions of non-payment made by an insurance company contracted by the insured to assist in payment of medical services. I authorize an associate from *CliniCare ID Consultants of CSRA* to act on my behalf, if necessary, to appeal decisions of non-payment, and to the insurance commissioner governing my insurance company. I permit a copy of this to be used as the original.

I understand and acknowledge that I am responsible for payment of any service not covered by my insurance plan and any unpaid balance beyond 30 days will cause finance charges to accrue at 1 1/2% per month or 18% annually.

⇨ _____ _____

Patient Signature or Authorized Person/Parent/Guardian Date