Consent to Treat, Financial Responsibility, and HIPAA Privacy Notification

HIPAA CONSENT & COMPLIANCE NOTIFICATION FOR OUR PATIENTS

The Department of Health and Human Services has established a "Privacy Rule" (HIPAA) to help ensure that personal healthcare information is protected and to provide a standard for healthcare providers to obtain their patients' consent for uses and disclosures of health information to carry out treatment, payment, or healthcare operations. We support your full access to your personal medical records. You may refuse to consent to the use or disclosure of your PHI (Personal Health Information), but this must be in writing. Under this law, we have the right to refuse treatment if you choose to refuse to disclose your PHI. If you choose to give consent, at any time you may request to refuse to disclose all or part of your PHI. You may not revoke actions that have already been taken based on this or a prior consent.

The misuse of Personal Health Information is a national problem causing inconvenience, aggravation and money. We want to reassure you that our employees undergo training to understand and comply with laws and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA). We welcome your input regarding any service problem so that we may remedy the situation properly. Thank you for being one of our highly valued patients.

AUTHORIZATION, ASSIGNMENT OF BENEFITS, AND REFERRAL MEDICAL RELEASE

I hereby authorize the release of medical information including complete medical records, test results and billing information to my insurance company/other medical professionals/medical care institutions that I may be referred to for treatment. I understand this information may be used to review, investigate, or make payment of a claim and/or to review records for quality improvement, audit compliance and complaint resolution. I authorize payment directly to Vineyard Medical Care for all medical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-pays, co-insurance, deductibles, and non-covered services. I agree to pay all collection charges including reasonable attorney fees, if necessary, to pursue payment of this account.

PRIVATE INSURANCE PATIENTS: Vineyard Medical Care accepts many major insurances, Medicare, and some MA state Medicaid. You are responsible for the bill should your insurance company decline payment. It is the Patient's responsibility to know their coverage.

HMO PLANS: You are required to obtain a referral from your primary care doctor for your visit. If you do not obtain the referral, you will be responsible for any charges for services rendered.

INSURANCES NOT ACCEPTED OR NO INSURANCE: We may provide services to patients that do not have insurance that we are contracted with, or do not have any insurance. All fees are due at the time of service. A claim summary may be provided to you in order to file with your insurance plan to request reimbursement.

LIABILITY INSURANCE: We may provide treatment for Worker's Compensation, Motor Vehicle or Personal Injuries. Patients are required to provide the claim number associated with the incident and the billing name and address.

METHODS OF PAYMENT: We accept CASH/CHECK/VISA/MC/DISCOVER/AMEX. We will NOT accept post-dated checks or hold onto checks for any length of time. Payment arrangements may be made as necessary. There is a $20 fee per returned check.

NO SHOWS: Any patient who fails to arrive for a scheduled appointment without canceling the appointment at least 24 hours prior to the scheduled time is considered a "no-show". Any patient who has a "no-show" appointment on record will be subject to a $50 no-show fee (this fee is not covered or reimbursed by insurance plans.)

Our billing office can be reached at 1-800-787-1596 to answer any questions or help make payment arrangements.

CONSENT TO TREAT

1. I give permission for Vineyard Medical Care to give me medical treatment.

2. I allow Vineyard Medical Care to file for insurance benefits to pay for the care I receive.
   I understand that:
   - Vineyard Medical Care will have to send my medical record information to my insurance company.
   - I must pay my share of the costs.
   - I must pay for the cost of these services if my insurance does not pay, or I do not have insurance.

3. I understand:
   - I have the right to refuse any procedure or treatment.
   - I have the right to discuss all medical treatments with my clinician.

I agree that I have read and understand the terms of this contract.

Patient Name (please print): _____ **Date of Birth:** _____

Signature: _____ **Date:** _____

If under 18, parent/guardian printed name: _____

Emergency Contact: Name: _____ Phone: _____ Relationship: _____

Vineyard Medical Care

Designate Family & Caregivers to pick up or discuss personal health information

Patient Authorization to Release Protected Health Information to Family, Caregivers or other designee(s)

I, _____, ____/____/____ authorize my health care
(Print Full Name) (Date of Birth)

providers/advocates of Vineyard Medical Care to release all medical and billing information; including mental health, laboratory and diagnostic testing including HIV, to the individual(s) named below. This authorization will become part of my medical record and will remain in effect until the date of my death.

I understand that my personal medical information may further be released by the designee(s) I have listed below, if those designee(s) are not required by law under the Health Insurance Portability and Accountability Act (HIPAA) to protect the privacy of the information, or in the event the information is no longer protected by federal regulations governing privacy regulations.

I understand I am authorizing release of my protected health information to my designee(s) as provided below, and that I may revoke this authorization, except to the extent that my health care providers have already taken action based on this authorization, at any time by notifying Vineyard Medical Care in writing.

*****Please advise us in writing if there is any exception to this release*****

I understand I am under no obligation to sign this authorization; however, it is **not valid unless signed.**

Please enter information of friends, family members and/or caregivers:

Name: **Address:**

Relationship to Patient: **Home #:** **Cell#:**

Name: **Address:**

Relationship to Patient: **Home #:** **Cell#:**

Name: **Address:**

Relationship to Patient: **Home #:** **Cell#:**

_____ _____
(Patient Signature) **(Date)**