COLORADO ARTHRITIS CENTER

Patient HIPAA Acknowledgement and Consent Form

Patient Name:____

Date of Birth: ____

___ **(Patient initials)** Notice of Privacy Practices. I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. To the extent permitted by las, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

___ **(Patient initials)** Release of Information. I hereby permit practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for the purpose of treatment, payment, or healthcare operations. Healthcare information regarding a prior admission(s) at other affiliated facilities may be made available to subsequent affiliated admitting facilities to coordinate Patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation. If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of Medicare claim or to the appropriate state agency for payment of a Medicare claim. This information may include, with limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary. Federal and State laws may permit this facility to participate in organizations with other healthcare providers, insurers and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information on another to accomplish goals that may include but not be limited to; improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information, aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious disease including, but not limited to, blood borne disease such as HIV and AIDS.

Patient Name: ____

Date of Birth: ____

Disclosures to Family Members and/or Friends

I give permission for my Protected Health Information to be disclosed for purpose of communicating results, findings and care decisions to the family members and others listed below:

Name	Relationship	Phone Number

1.____

2. ____

3.____

Prescription Order Pick Up

There may be times when you need a family member or friend to pick up a prescription order (Script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

____ (**Patient's initials**) I wish to designate the following family member/friend to pick up an order on my behalf:

Name:____ **Date:**_____________
Name:____ **Date:**_____________

____ (**Patient's initials**) I do not want to designate anyone to pick up my prescription order.

Patient Signature____ **Date:**_______________

Release

____I would like Colorado Arthritis Center to leave a message of a non-sensitive nature that may contain protected health care information on my voice mail, answering machine or with a family member, **OR**

____I would like Colorado Arthritis Center to leave a message of a non-sensitive nature that may contain protected health information on my voice mail, answering machine or with a family member only at the following designated phone number: _________________________________**OR**

____I do not wish to have Colorado Arthritis Center leave me a message containing protected health information.

Patient Signature:____ **Date:**________________

Colorado Arthritis Center

PRESCRIPTION REFILL POLICY

For all prescription refill requests, please contact your pharmacy first. They will fax an authorization with your prescription information for the doctor to review. Please note there is a minimum 24-hour turnaround time for ALL refill requests. Please monitor your medications carefully and call BEFORE you run out of your supply.

CANCELLATION POLICY

In order to offer you the best care possible, it is important that you keep your appointment with your physician. If you need to cancel an appointment, please give at least 24 hours' notice. If you need to cancel or reschedule the same day as your appointment, please call to let us know so that we can offer the time to patients who are on the cancellation list. Failing to call and cancel or reschedule PRIOR to the appointment is counted as a 'NO SHOW" and you will be charged a $50.00 fee. We reserve the right to dismiss you from our care after three "NO SHOW" occurrences; please be considerate of other patients in need of appointments.

FINANCIAL POLICY

We provide the best possible care and service to you and regard your complete understanding of our financial policies as an essential element of your care and treatment.

- Unless other arrangements have been made in advance by yourself or your health coverage carrier, full payment for office services are due at the time of service. For your convenience, we accept VISA, MasterCard, American Express and Discover, as well as cash, check or money order.
- We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the copayment at the time of service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered" you will be responsible for the complete charge. Payment is due upon receipt of statement from our office.
- It is your responsibility to verify this office participates with your insurance. If we do not participate with your insurance, you will likely be responsible for all charges out of pocket.
- If you have an HMO insurance plan, it is YOUR responsibility to make sure you have a referral for our office from your PCP prior to your first visit. Failure to do so may result in reduced benefits and/or non-coverage of your visit by your insurance company.

By signing below, I acknowledge I have read and understand the financial policy of the practice and I agree to be bound by its terms. I authorize the release of any information necessary to my insurance company or its intermediaries to process this claim and all future claims.

Patient Signature **Date**

Printed Name **Date of Birth** **Relationship to the patient/minor**