Center for Health Internal Medicine Associates
645 N. Arlington Ave., Suite 600, Reno, NV 89503

updated 11/2015

HIPAA

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- ✓ Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly or indirectly.
- ✓ Obtain payment from third-party payers.
- ✓ Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that I have a right to request restrictions in writing as to how my health information may be used or disclosed to carry out treatment, payment or health care operations. I understand that this organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing at any time except to the extent that you have taken action relying on this consent. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code and Federal Regulations. Revocations will only be accepted in person or via certified U.S. mail. I understand that as part of this organization's treatment, payment or healthcare operations, it may become necessary to disclose my protected health information to another entity and I consent to such disclosure for these permitted uses including disclosure via fax.

□ I fully understand and accept the terms of this consent.
□ I fully understand and decline the terms of this consent.

According to HIPAA regulations, we are required to keep your health information confidential. You have the right to restrict family members or other persons from accessing your health information. However, we are aware that many of our patients do not wish to restrict their spouse, family member or other person from having access to their health information. In effort to comply with HIPAA regulations and to avoid inconveniences for our patients, we are asking that you please fill out the following questionnaire. If at any time you wish to change any information on this form, please notify our office in writing and we will honor your request.

Please list the family members or other persons, if any, who we may inform about your medical condition and check the boxes beside their names where applicable.

- Name:_____ _____ □ ONLY IN AN EMERGENCY □ We may disclose all and any medical information.

  Relationship:_____ Phone Numbers:_____

- Name:_____ _____ □ ONLY IN AN EMERGENCY □ We may disclose all and any medical information.

  Relationship:_____ Phone Numbers:_____

- Name:_____ _____ □ ONLY IN AN EMERGENCY □ We may disclose all and any medical information.

  Relationship:_____ Phone Numbers:_____

ADVANCED DIRECTIVES

Do you have an advanced directive? □ Yes - please allow us to keep a copy in your medical record.
□ No – Would you like information regarding Advanced Directives? □ Yes □ No

FMLA/DISABILITY PAPERWORK

As part of our service to you, we complete FMLA paperwork within 5 business days of receipt of paperwork. There is a $25 charge for this. For disability paperwork, there will be a $50 charge. We charge these fees in order for us to maintain a high quality level of service. All fees are due upon receipt of the requested paperwork.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize my insurance benefits to be paid directly to the physician/ Center for Health Internal Medicine Associates. I understand that I am financially responsible for any balance. Also, I authorize the Center for Health Internal Medicine Associates to release any information required to process my claims. I authorize the use of my signature on all insurance submissions. I authorize permission to download my medication history.

I have read and understand these policies and hereby acknowledge receipt of a copy of this form and agree to its terms.

Patient/ Responsible Party Signature:_____ Print Name:_____ Date:_____

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Welcome to our office. We are committed to providing the best, most comprehensive care possible. Please assist us by providing the following information.
Is the address on your driver's license current? □ Yes □ No- new address:_____

Phone numbers: Home:_____ Work:_____ Mobile:_____

Occupation/or if Retired, From Where? _____

Employer's Name:_____ Address:_____

Spouse's/Legal Partner's Name:_____
Due to new healthcare incentives provided to physician's offices by the government, we have been asked to gather the following information: **Primary Language Spoken**: □ English □ Spanish □Other _____
Race: □American-Indian □Asian □Black □Pacific Islander □ White □Not Provided
Ethnicity: □African American □American □Arabian □Asian-Indian □Chinese □European □Hispanic □Japanese □Spanish □Other_____
We are in the process of implementing a patient portal via the internet. This will make requesting refills, requesting appointments and updating your demographics easier. Please provide us with your email so we may provide you with updates.

Email address:_____
You may also learn more about us at www.centerforhealthimreno.com. Thank you for choosing us to be your healthcare providers.

Below and attached are some of our policies. Please discuss with us if you have any questions or concerns about the below.

FINANCIAL/ INSURANCE POLICY

Your health insurance is based upon a contract between the insured party's employer and the insurance company, or in some cases, between you and the insurance company. We are not a party to that contract. Our relationship is with you, not your insurance company. It is the responsibility of the insured party who benefit from this plan or who receives benefits from this insurance plan to know:

1. The commencement date of the plan.
2. If there is an annual deductible and how much.
3. Which hospital, laboratory and radiology center the carrier is contracted with. Which is your preferred facility?_____
4. The amount of your co-pay. **Co-pays are due at the time of service. If you cannot pay your co-pay then a $10 administrative fee will be charged in addition to your co-pay.** Per the contract we signed with your insurance company, your co-pay is to be collected, in its entirety, at the date of service. Any questions, please speak to the office manager.

It is your responsibility to present the insurance card to the receptionist when checking in. It is also your responsibility to notify the staff of any changes or termination of your plan. All charges are your responsibility whether your insurance company pays or not. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select services they will not cover. The contract between the Center for Health Internal Medicine Associates with any insurance company is:

1. To provide quality medical care to the patient.
2. To submit the claim for service to the appropriate carrier in a timely fashion.
3. To give credit to the patient for any "contracted discount".
4. To collect co-pays and other balances due from the patient at the time of service.

If the insurance company does not pay in full **within 60 days**, we require you to pay the **balance due** with cash, credit card or check. If you fail to pay any overdue balances and/or fail to commit to a pre-arranged payment plan, your account may be forwarded for further collection action, which may include, but is not limited to, late fees, attorney fees, and possibly third party collection agencies. All costs associated to this action will be the responsibility of the patient or financially responsible guardian.

We accept personal checks; however if any check comes back to us for non-sufficient funds, we charge a fee of $20 which covers the bank charges we incur. Future payments will need to be made with cash or credit card.

We understand that temporary financial problems may affect timely payment of your balance; in fact, we encourage you to communicate any such problems so that we can assist in the management of your account. If you have any questions or concerns about this financial policy, please do not hesitate to ask the practice manager.

MISSED APPOINTMENTS

We request that when you cancel an appointment please do so **at least 24 hours** prior to scheduled appointment time. If a 24 hour notice is not received or you miss an appointment without prior notification, you will be **charged $50.00**. After 2 no show appointments or appointments cancelled without 24 hour notice, you are subject to be discharged from our practice.

I have read and understand these policies and hereby acknowledge receipt of a copy of this form and agree to its terms.

Patient/ Responsible Party Signature:_____ Print Name:_____ Date:_____