PATHWAY
FOOT & ANKLE CENTER

HIPAA ACKNOWLEDGEMENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name _____

Signature _____

Signature Date _____

Relationship to Patient (if patient unable to sign) _____

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Your understanding of our financial policies is an essential element of your care and treatment.
If you have any questions, please ask to discuss them with our supervisor.

**** PLEASE INITIAL that you have read each of the practice policies below regarding patient financial responsibility ****

☐ As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.

☐ Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, Discover, cash, or check.

☐ Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctors. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within 60 days, you will receive a bill.

☐ 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," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.

☐ You must inform the office of all insurance changes and authorization/ referral requirements. In the event the office is not informed, you will be responsible for any charges denied.

☐ There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery or at the time of your Pre-op appointment.

☐ Patients who are 90 days past due on their balance will be sent to collections unless a payment plan has been put into place. Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due to the office.

☐ There is a fee of $25.00 for all returned checks. Your insurance company does not cover this fee.

☐ We understand that emergencies occur but repeated no shows or cancellations with less than 24 hours' notice will result in a fee of $25.00. You might be asked to pay before you are seen by the doctor. Patients who come to office fifteen minutes later than scheduled appointment might be asked to reschedule.

Signature of Patient/ Responsible Party: _____ Date: _____

Printed Name of Patient/ Responsible Party: _____ Date: _____

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HIPAA COMPLIANCE PATIENT CONSENT FORM

The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. The terms of this notice may change. If so, you will be notified at your next visit to update your signature and date.

By signing this form, you consent to our use and disclosure of your protected healthcare information according to the indications below.

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- This privacy policy may be changed by the practice, when necessary, as required or allowed by law.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- This privacy policy will stay in effect until the time that it is revoked by the patient or changed as required by law.

PLEASE INDICATE YOUR PREFERENCES REGARDING YOUR PERSONAL HEALTHCARE INFORMATION:

Health notifications:	____ E-mail	____ Phone	____ Text message
Prescription Notifications:			____ Text message only
Auto Appointment Reminders:	____ E-mail	____ Phone	____ Text message
Practice Announcements:	____ E-mail	____ Phone	____ Text message
Billing information:	____ E-mail	____ Phone	____ Text message

I consent to have my medical records shared with other Pathway Foot & Ankle Center providers. ____ Yes ____ No
I consent to have my medical records shared with my care providers outside of Pathway Foot & Ankle Center . ____ Yes ____ No

May we discuss your medical condition with a family member? ____ Yes ____ No
If YES, please list the name of the members allowed:
_____ Relationship to patient _____
_____ Relationship to patient _____

AUTHORIZATION TO RELEASE DETAILED BILLING DOCUMENTS AND/OR PERSONAL MEDICAL RECORDS VIA EMAIL

Pathway Foot & Ankle Center is dedicated to keeping your medical record information confidential. Due to the nature of email and texting, despite our best efforts, third parties may have access to these messages. Please be aware that some companies consider email and text messages corporate property, and messages sent via work emails may be monitored. Even when emailing to/from your home or mobile phone, access to email may be unsecure or may be uncontrolled.

I understand that Pathway Foot & Ankle will NOT be responsible for information loss, delay, or breach of confidentiality due to technical issues beyond our control. By selecting AUTHORIZE below, you are agreeing that we may send medical related correspondence to you via email, and that we may respond in the same way to your emails.

☐ **I DECLINE** this option. I have read and understand the risks in sending my personal information via email and decline.

☐ **I AUTHORIZE** to have my personal information sent via email. I have read and understand the risks in sending personal information via email, however, upon my request, **I AUTHORIZE** that my personal MEDICAL RECORDS or DETAILED BILLING DOCUMENTS may be sent via email. **My Preferred Email Address**: _____

PRINTED NAME OF PATIENT: _____ DATE OF BIRTH: _____
Patient or Guardian Signature: _____ DATE: _____

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Financial Payment Policy

First Name: _____ **Last Name:** _____

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Full payment is due at the time of service unless your health insurance carrier has made prior arrangements. For your convenience we accept cash, checks or credit cards (i.e.; VISA, Mastercard, Discover and American Express)
We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized copayment at the time of service. This offices policy is to collect this copayment when you arrive for your appointment.
If your insurance requires a referral it is **your responsibility** to provide the referral to our office prior to seeing the physician. If unable to provide the referral prior to the visit payment in full will be required at the time of the visit.
If you have Medicare you are responsible for your Medicare deductible (when applicable) at the time of service.
If you have a secondary insurance plan, as a courtesy, we will forward any balance due to this carrier. If the secondary carrier does not process/pay the claim within 4 weeks, then the balance will become patient responsibility.
If you have insurance coverage with a plan for which we **do not** participate, we will prepare and send the claim for you on an unassigned basis. This means that your insurer will send the payment directly to you. Consequently, the charges for your care and treatment **are due at the time of the service**.
In the event that your health plan determines a service to be not covered, you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
We will bill your health plan for all services provided in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office.
Failure to cancel your appointment within 24 hours of your scheduled appointment time will result in $_____ charge.
Coverage Changes - If your insurance changes, it is your responsibility to present the office with the new insurance information. Failure to do so may result is 100% patient responsibility for the uncovered visit.
Copay - The copay is an amount that your health plan requires to pay at the time of service. The payment is due on the date of service.
Annual Deductible - An annual deductible is an amount that your health plan requires you to pay toward your health care costs each year. If you have not met your deductible at the time of service at our office, you will be responsible for payment on that date of service.
Balances - Any processed claims with unpaid balances will be collected at a subsequent visit.
Patients without Insurance - If you do not have insurance or **cannot present a valid insurance card** at the time of service, payment in full will be required.
Returned Checks - The is a servcice fee of **$**_____ for returned checks

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the financial payment policy of _____ and agree to abide by its guidelines.

Signature: _____ Date: _____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purposes of providing health care services to you, to pay your health care bills, to support the operation of the physician’s practice, and any other use required by law.

Your Protected Health Information may be subject to electronic disclosure. We will obtain an authorization from you to authorize any electronic disclosure other than for treatment, payment, or health care operations purposes.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician’s practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be

asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

We may use or disclose your protected health information for the following situations without your authorization. These situation include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and human services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made **only with your consent, authorization** or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) - Pursuant to your written request, you have the right to inspect and copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you to another person, or information that was obtained under the promise or confidentiality.

You have the right to request a restriction of your protected health information - This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested except if you request that the physician not disclose protected health information to your health plan with respect to health care for which you have paid in full out of pocket.

You have the right to request to receive confidential communications - You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information - If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures - You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; require, that occurred prior to April 14, 2003, or six years prior to the date of the request.

You have the right to receive notice of a breach- We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such charges on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature: Date: