

## **Protected Health Insurance (PHI)**

Due to recent implemented Federal Regulations the following public notice by MD Immediate Care is effective as of November 1, 2011. **The MD Immediate Care** is required to: Maintain the privacy of your health information. Provide you with this notice as to what our legal duties and privacy practices are with respect to information we collect and maintain about you. Abide by the terms of this practice. Notify you if we are unable to agree to a requested restriction, and accommodate any reasonable request you may have to communicate health alternative means or alternative locations. We will not use or disclose your health information without your authorization, except as described in this notice. We will use and disclose your PHI in order to bill and collect payment for the services and items you may have received from us. For example, we will contact your insurer to certify that you are eligible for benefits and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment.

### **WE ARE PERMITTED TO USE, AND MAY BE REQUIRED, TO DISCLOSE YOUR PHI UNDER SPECIAL CIRCUMSTANCES:**

1. **Disclose Required By Law:** Our practice will use and disclose your PHI when we are required to do so by federal, state, or local law, including health oversight activities, court or administrative orders or similar legal proceedings.
2. **Public Health Risk:** Our practice may disclose your PHI to public health authorities who are authorized to collect information for such purposes as maintaining vital records, preventing or controlling disease, injury, or disability; or notifying a person regarding potential exposure to a communicable disease.
3. **Serious Threats to Health or Safety:** Our practice may disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public.
4. **Deceased Patients:** Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.
5. **Organ Donor:** Our practice may release PHI to a medical facility for tissue procurement of transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.
6. **Worker's Compensation:** Our practice may release your PHI for workers' compensation and similar programs. Our practice may contact you or your authorized representatives (see authorization form attached) to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to

you. The practice might routinely contact patients via telephone at home and /or work, via mail at home, and unless otherwise requested, may leave messages on the appropriate voice mail or answering service regarding appointments and billing questions. All requests for medical records should be hand written and should contain: Full Name Date of Birth Mailing Address Phone Number Written Signature An additional fee might be asked for generating a copy or mailing all medical records as per the rules practiced by the clinic. At no time will any person, including your spouse, be able to obtain information from your medical record without prior written authorization. Only parents or legal guardian of a child under the age of 18 will be allowed to access medical record information, with proof of child's social security number and date of birth.

### **Patient Rights**

1. **Confidential Communications:** You have the right to request that our practice communicate with you about health and related issues in a particular manner or at a certain location. Our practice will accommodate reasonable request.
2. **Requesting Restrictions:** You have the right to request restriction on our use of disclosure of you PHI for treatment, payment, or health care operations. We are not required to agree to your request; however if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. **Inspection and Copies:** You have the right to request and obtain a copy of your PHI. Our practice will charge a fee for the cost of copying, mailing, labor, and supplies associated with your request. Our practice may deny your request to inspect and/or copy limited circumstances. However, you may request a review of our denial.
4. **Amendment:** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for this practice. Your request must provide us with the reason that supports your request for amendment. Your request may be denied if you ask us to amend information that is in our opinion: a) accurate and complete; b) not part of the PHI kept by or for the practice; c) not part of the PHI that you would be permitted to inspect and copy; or d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.
5. **Rights to a paper Copy of This Notice:** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time.
6. **Rights to File a Complaint:** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing a complaint. If you have any questions regarding this notice or would like to exercise any of your rights under this

notice, you may contact:

MD Immediate Care 504

Lewis Street Havre De Grace MD20178-3420

Phone 443-502-5311MD

Immediate Care **\*\*Complete and return to Receptionist\*\***

**ACKNOWLEDGEMENT**

I acknowledge that I have received the Notice of Privacy Practices from MD Immediate Care and understand that if I have questions regarding this Notice I may contact the office at:

504 Lewis Street, MD 20178-3420. Phone: 443-502-5311. Indicated below are names of any Person(s) to whom I would like MD Immediate Care to allow disclosure of Individually Identifiable Health Information (IIHI). (Please, specify the type of information that may be disclosed, such as lab test, appointment information, prescription information, etc. You may indicate "All" if appropriate). Name: Relation to Patient: Allowed Disclosure:

Patient Name

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## HIPAA Consent Form

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), established a Privacy Rule to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations. As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate or necessary, we provide the minimum necessary information only to those we feel are in need of your health care information regarding treatment, payment or health care operations, in order to provide health care that is in your best interest. We fully support your access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with the physician and not patients), and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent. We have chosen to participate in the Chesapeake Regional Information System for our Patients (CRISP), a regional health information exchange serving Maryland and D.C. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may "opt-out" and disable access to your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website at [www.crisphealth.org](http://www.crisphealth.org). Public health reporting and Controlled Dangerous Substances information, as part of the Maryland Prescription Drug Monitoring Program (PDMP), will still be available to providers. You may refuse to consent to the use or disclosure of your personal health information, but this must be done in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information. If you choose to give consent in this document, at some future time you may request to refuse all or part of your Personal Health Information. You may not revoke actions that have already been taken which relied on this or a previously signed consent. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our Privacy Notice (Compliance Assurance Notification to Our Patients), to request restrictions and revoke consent in writing. Patient

**Signature:**

**Date:.**

## FINANCIAL RESPONSIBILITY ACKNOWLEDGMENT & ACCEPTANCE LETTER

Insurance Name:

This letter is to inform you that in any case that your insurance does not cover the services received, you will be responsible for paying the full cost of the service. You will receive a bill from our office for the services provided to you that were not covered by your insurance. RE; Hospital, Radiology and Laboratories in network, I understand that it is my responsibility to know which hospital's radiology and laboratories are covered under my insurance plan. I also understand that I will be responsible for payment of any balance due to these facilities should I go to a non network facility. Please sign in the space below to signify your acceptance of financial liability for these services.

Acknowledgment

I have read and understand this letter and still would like to receive these services. I will accept full financial responsibility for the cost of the services. I understand that I will receive a bill for the cost of the service(s) and agree to pay such a bill in timely manner.

Patient Signature:

Date: