HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

PATIENT CONSENT FORM

To our patients: We appreciate your indulgence with these consent forms which are now required by new Federal regulations.

The Health Insurance Portability and Accountability Act has been established to help insure that personal health information is protected for privacy and to provide a standard for health care providers to obtain their patients' consent for uses and disclosures of health information about the patient in order to carry out treatment, payment, and office procedures related to your health care.

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, we provide necessary information to those involved in your health care in order to provide health care that is in your best interest. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act. We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

We also want you to know that we support your full access to your personal medical records. You may refuse to consent to the use or disclosure of your personal health information, but this must be 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 in writing revoke this consent. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

I give my consent to have my picture taken at the beginning and during the course of my treatment, if need be. I understand that pictures will be used to access and monitor the progress of my treatment, to provide proof of medical necessity to my insurance company, and may be used without my name for educational and teaching purposes.

I give my consent to the staff of William Russell, MD to call in advance and remind me of my upcoming appointments or to discuss test results, treatment plans, etc. You may try to reach me at home or at work. If I am not available to answer the phone I would like an employee to leave me a brief message reminder. I am aware that if I do not appear at a scheduled appointment which I have not canceled with twenty-four hours advance notice, I can and may be billed $50.00.

I give my consent to have a summary of my evaluation and results of my testing and treatment sent to my primary care physician and other physicians involved in my healthcare.

Signature:____ Date:__________