

DFW Neuropathy HIPAA Form

Consent for Treatment and Payment Agreement

I hereby authorize DFW Neuropathy to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and healthcare operations. I understand that while my consent is voluntary, if I refuse to sign this consent, the healthcare providers of DFW Neuropathy may refuse to treat me. I authorize the physicians to administer such treatment as they deem advisable for my diagnosis and treatment. I certify that I have been made aware of the role and services offered by the physician, PA (physician assistant) or NP (nurse practitioner) and I consent to care by such providers. I understand that these services are voluntary and that I have the right to refuse these services. This consent will remain in full force unless revoked in writing and will not affect any actions that were taken prior to receiving my revocation. A photocopy of this consent shall be considered valid as original.

Patient and/or guarantor are responsible for charges incurred. It is a courtesy for our office to file with your insurance; however, you may be responsible for your co-pay and or percentage which the insurance is not responsible for on the day of your visit. It is the patient's responsibility to obtain referral forms from your primary care physician when and if required. If the referral is not obtained before the visit, the patient is liable for payment in full on the date of service. If we are unable to obtain payment within a reasonable amount of time from the patient/guarantor we will place your account with a collection agency which will leave you liable for any additional charges incurred. I have fully read and understand the above payment policy. I agree to forward to DFW Neuropathy, all insurance or third party payments that I receive for services rendered to me immediately upon receipt.

MEDICARE LIFETIME AUTHORIZATION

I certify that the information given to me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration of its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payments of authorized benefits be paid on my behalf. I assign the benefits payable for services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment. I request this authorization also apply to all other insurance.

* **Patient Signature** _____ **Date** _____

RELEASE OF MEDICAL INFORMATION

Please let us know the names of which we may release health information to or may be allowed to enter the exam room during discussion regarding health information. I understand that at any time a physician, PA, NP and/or a medical assistant will be present in the exam room for training purposes and I may request individuals to leave the exam room at any time.

Authorized persons	(Information)	(Exam Room)
_____	Y N	Y N
_____	Y N	Y N
_____	Y N	Y N

*If the requestor/receiver of information is not a healthcare provider, the released information may no longer be protected from re-disclosure

What information may we release?

____ All PHI (Personal Health Information)	____ Appointment information	____ Other
____ Office notes	____ Prescription	
____ Lab/ Diagnostic test results	____ Billing information	

This information may be released by: _____
Phone# _____
Fax # _____
Mail: Address _____
Other (please be specific) _____

* **Patient Signature** _____ **Date** _____

Notice of Privacy Practices

I hereby acknowledge that I have received or been provided the opportunity to receive a copy of the HIPAA privacy policies and understand that any questions or complaints may be addressed to the Privacy Office (Office Manager) without penalty.

* **Patient Signature** _____ **Date** _____