PATIENT'S BILL OF RIGHTS
and OUR COMMITMENT TO YOU

You have the right to:

Be Treated with Respect

It is our privilege to serve every patient that comes through our door. We pledge to serve patients with consideration and without discrimination at all times. It is your right to receive optimum health care without prejudice.

Participate in Your Healthcare

You have the right to all information you need to make the best decisions, including treatment options, test results, and an explanation of costs involved. You have the right to accept or reject a treatment plan. Your care will be improved if you participate in the decisions regarding your health.

Access Your Medical Records

Your medical records are kept in the office, but it is your medical information and you have the right to access them. You may order a copy of your record at any time for a small administrative fee.

A Second Opinion

As a patient, you must not hesitate to ask your medical provider if you need a second opinion.

Confidentiality

You have a right to talk in confident with your healthcare provider and within legal limits, to have your privacy protected at all times.

Be Examined in Private

Your provider may be working a healthcare student. You have the right to request that your examination is performed without anyone else in the room (unless a chaperone is required for sensitive exams).

PATIENT FINANCIAL AND INSURANCE POLICY

HIH will file a claim to your insurance carrier for medical services rendered. There may be instances when your insurance carrier may process your claim differently than quoted to HIH because:

1. Benefit payment is less than anticipated thereby leaving you with a higher responsibility.
2. Claim may be denied as non-covered.

Determination of Insurance Benefits:

Harmony in Health (HIH) will contact your insurance carrier to verify coverage, however, this **does not obligate insurers to make payment on your medical claim.** If you receive an Explanation of Benefits from your insurance carrier with a medical claim processed differently than you expected, **please contact YOUR CARRIER for clarification.** There may be instances (based on diagnosis or services rendered) that your insurance carrier will not provide benefits, therefore you will be held responsible for the balance. HIH will provide services they deem medically necessary which **may or may not** coincide with your insurance plan's policy.

You should know the following about your plan:

1. Your annual deductible
2. Your office visit co-pay

It is your responsibility to familiarize yourself with details regarding your specific benefit package. HIH is not responsible for determining the specifics of your plan, as benefits can vary greatly by region, employer and your individual coverage selections at enrollment.

HANDLING OF PERSONAL HEALTH INFORMATION

HIPPAA (Health Insurance Portability and Accountability Act of 1996; a federal law) requires healthcare organizations to comply with specific rules (Notice of Privacy Practices) regarding your Protected Health Information (PHI).

With my consent, HIH may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to HIH's **Notice of Privacy Practices** online for a complete description of such uses and disclosures.

DEMOGRAPHICS

Patient Name:_____

Birth Date_____ **SSN**:_____

Home Address:_____

_____

Phone Number:_____

Email Address:_____

Insurance

Insurance Carrier:_____

Insurance Ph #:_____

Subscriber ID#_____ **Group No.**_____

Copay_____ **Annual Deductible**_____

Policy Holder (check here for yourself☐):

Name_____ **Date of Birth**_____

Employer

Employer Name_____

Employer Phone_____

Employer Address

Occupation_____

Emergency Contact

Name: _____

Phone:_____

How did you hear about us?

How may we leave messages pertaining to your health (i.e. lab results, updates, etc)? Check all that apply:

☐ Email ☐ Phone ☐ Mail

By signing, I attest that the above is true to the best of my knowledge. I also understand and agree to the terms listed under patient financial and Insurance Policy. I further understand that I am financially responsible for any co-payments, deductible, co-insurance and non-covered services as outlined by my health plan.

Name:_____**Signature:**_____**Date:**_____