Hyde Park Pediatrics

Patient Name _____ DOB _____

Acknowledgement of Receipt of Notice of Privacy and Policy Practices

Health Information Privacy:

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that provides protection for your personal health information. One of the requirements of HIPAA is that we give you our Notice of Privacy and Policy Practices that describes your rights and protections regarding your personal health information.

I _____ acknowledge that a copy of Hyde Park Pediatrics Notice of Privacy Practices and Policies was made available to me.

Staff: If the patient did not acknowledge receipt of Notice above, you must document your efforts to obtain the acknowledgement and the reason why it was not obtained.

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Signature of Patient (if 18 years old or older) or Legal Guardian if Patient is a minor Date

Assignments of Benefits / Payment and Insurance Reimbursement:

This office will bill your insurance company for services provided. This office DOES NOT accept responsibility for collecting or failing to collect insurance claims, and you acknowledge that you are responsible for payment for any services provided and that you will pay all charges due and owed to the practice (including any co-pays and/or deductibles).

The practice will initiate payment of your claims for benefits (and may also process appeals from decisions related to your claims and benefits). It is necessary for all responsible parties to give us certain rights and permissions;

2) I (as patient or as agent of the patient) hereby assign and transfer all rights of third party payor benefits for services rendered to me to Hyde Park Pediatrics and authorize any insurance or third party payments to be made directly to the Hyde Park Pediatrics.

3) I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act, or under the terms of any other carriers, is correct. I request that payment of authorized benefits be made on my behalf pursuant to the above assignment.

4) I understand that in consideration of the services to be rendered, I am responsible for payment for any services not covered by third party payors, and I will pay any and all charges due and owing Hyde Park Pediatrics in accordance with their regular rates, terms and policies.

_____

Signature of Patient (if 18 years old or older) or Legal Guardian if Patient is a minor Date

Authorization for Release of Health Information

Patient Name _____ DOB _____

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

I understand that:

1. Hyde Park Pediatrics uses SureScripts, Inc. a prescription system that allows prescriptions and related information to be exchanged between my providers and the pharmacy. The information sent between these systems may include details of any and all prescription drugs I am currently taking and/or have taken in the past. This information will be utilized to Hyde Park Pediatrics.
2. This authorization may include disclosure and prescription information related to alcohol and drug abuse, mental health treatment and /or confidential HIV related information by SureScripts, Inc. to Hyde Park Pediatrics.
3. I have the right to revoke this authorization at any time by writing to Hyde Park Pediatrics. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be re-disclosed by the recipient, and this re-disclosure may no longer be protected by state or federal law.
6. This authorization expires one year from the date of my signature below.
7. THIS AUTHORIZATION DOES NOT AUTHORIZE HYDE PARK PEDIATRICS TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CALRE WITH ANYONE OTHER THAN THOSE PERMITTED UNDER APPLICABLE LAW.

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Signature of Patient (if 18 years old or older) or Legal Guardian if Patient is a minor Date