_____ DOB: _____

Patient Name (Please Print)

GETTYSBURG FAMILY PRACTICE

PROTECTED HEALTH INFORMATION DISCLOSURE

The Federal Government has entered into law the Health Insurance Portability & Accountability Act (HIPAA) privacy rule that gives individuals the right to restrict the use and disclosure of their Protected Health Information (PHI). As part of Gettysburg Family Practice, Inc's compliance with the HIPAA Privacy Rule, we will not use or disclose any PHI without your authorization for purposes other than treatment, payment, or healthcare operations, unless HIPAA specifically permits such use or disclosure. Access to the 2013 HIPAA Privacy Notice will be given to the patient and/or his/her representative via www.gettysburgfamilypractice.com, a paper copy of the notice if requested, or reviewing the posted notice in the office. Please review the following carefully and sign as your authorization for contacting you and for release and disclosure of your PHI.

I authorize Gettysburg Family Practice, Inc. to contact me by the following means: (Please check✓ all that apply)

Home telephone	Yes_____	No_____	Phone Number:_____
Home answering machine	Yes_____	No_____	
Work telephone/voicemail	Yes_____	No_____	Phone Number:_____
Cellular phone/voicemail	Yes_____	No_____	Phone Number:_____
Email	Yes_____	No_____	Email Address:_____

List of Authorized Person(s) to whom your Protected Health Information can be discussed:

Name_____Relationship_____Phone#_____

Name_____Relationship_____Phone#_____

Name_____Relationship_____Phone#_____

I understand that I may revoke this authorization at any time by notifying Gettysburg Family Practice, Inc. in writing, but if I do, it will not have any effect on any actions taken by Gettysburg Family Practice, Inc. prior to receiving my revocation. I also acknowledge that I have received notification of the location of the Privacy Practices for Protected Health Information at Gettysburg Family Practice. Inc.

INSURANCE COVERAGE DISCLOSURE

I hereby authorize payment of authorized Commercial Benefits, Medicare or Secondary Medicare coverage benefits be made directly to Gettysburg Family Practice on my behalf for any services rendered to me by that provider of service. I understand that I am financially responsible for charges not covered by this authorization. I authorize any holder of medical information about me to release to my insurance company or its agents any information which may be necessary to determine benefits payable for related services.

- Payment is expected at time of service. We accept cash, check, or credit card (Visa, MasterCard, or Discover).
- We participate with a wide variety of insurance companies. It is the patient's responsibility to know the terms of their own plan. Not all services are covered in all insurance contracts. If your insurance plan does not cover a service or procedure, you may be liable for full payment of the bill. To find out what your plan covers and what your financial obligation may be, call the Customer Service or Member Services Department of your insurance company (the phone numbers are listed on the back of your insurance card).
- Patients covered under a "participating" plan will be responsible for their co-pay at time of service. A $10.00 late co-pay fee will be added to the bill, if not paid at time of service.
- If you are entitled to certain preventative tests per year, please make us aware in writing so we may bill your insurance company appropriately. If we are not made aware prior to submitting your claim to the insurance company, we are unable to change the diagnosis after it has been billed.
- If a response to a claim has not been received from your insurance company within sixty days after billing, the balance becomes your responsibility. **The arrangement of the insurance company to pay for medical care is between you and the insurance company**.
- Patients with a plan that we do not participate with, are required to pay at time of service and will be provided with a bill to submit to the insurance. In the event there is an unpaid balance on the account, payment in full or payment arrangements must be made prior to scheduling an appointment.
- If your insurance company requires a referral for services outside of our office, it is your responsibility to make sure that you have the necessary paperwork from our office.
- Any services not covered or denied by Workers' Compensation or automobile insurance will become your responsibility
- We ask that you kindly give a 24 hour notice if you are unable to make your scheduled appointment. There will be a $50.00 charge for failed appointments, or failure to give a 24 hour notice.

I understand and agree that I am ultimately responsible for the balance on my account. I have read the above payment policy, Protected Health Information Disclosure and Insurance Coverage Disclosure and agree to all of the terms outlined.

X_____ _____

Signature of Patient or Parent (if minor) Date

REV 06/03/16