



"Caring for our Community"

PRIVACY PRACTICES/ASSIGNMENT OF BENEFITS

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

Uses and Disclosure

Treatment. Your health information may be used by staff members or disclosed to other healthcare professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of lab tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Operations. Your health information may be used as necessary to support the day-to-day activities and management of Duson Family Healthcare. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Public Health Reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the states' public health department.

Other Uses and Disclosures Require Your Authorization. Disclosures of your health information or its use for any purposes other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use of disclosure of information that occurred before you notified us of your decision to revoke your authorization.

ASSIGNMENT OF BENEFITS

I hereby assign to Duson Family Healthcare any insurance or other third-party benefits available for healthcare services provided to me. I understand that Duson Family Healthcare has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Duson Family Healthcare, I agree to forward to Duson Family Healthcare all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt.



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continued

CONSENT FOR CLINICAL SERVICES

I hereby give my consent to Duson Family Healthcare to solicit medical and personal history from me and maintain information as part of my personal file in the clinic. As a patient, I will accept all tests, examinations and prescriptions and accept to be treated by an Advanced Practice Registered Nurse. I understand that all information in my file will be kept confidential and will not be given to any person/agency within the office of Duson Family Healthcare without prior approval by me.

I hereby consent to the following treatment:

Administration and performance of all treatments

Administration of any needed anesthetics

Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient

Use of prescribed medication

Performance of diagnostic procedures, tests and cultures

Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending Nurse Practitioner, physician or other assigned designees.



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FINANCIAL POLICY

PATIENT RESPONSIBILITY FOR FEES

We require that our patients promptly pay all charges that we present to them. In some cases, our fees may be adjusted, based on whether we participate in or accept insurance or government program payments, allowances, or limitations. But, if we present a charge to you, it means that we have taken any such adjustment into account and that you must still pay the amount remaining. If you are reimbursed directly by an insurance company for the cost of your care, you must still pay our charges promptly, whether or not you have received that reimbursement.

If you do not agree with patient responsibility amounts or reimbursement amounts set by your insurance company, this is a matter between you and that company. We are happy to provide you with factual information about your care and billing to help you discuss this with them, but we still require you to promptly pay the entire charge we present to you, even if the issue with the company is not resolved.

Payment for our services are due **PRIOR TO** services being provided to you. This includes, among other things, copay amounts, deductibles, earlier charges that remain unpaid, and charges for services that we believe are not covered by, or are left over as your responsibility to pay after coverage by insurance company. We or our agents may send you statements and reminders of charges made and amounts that we believe must be paid, or may call you about the same. We expected these charges to be paid promptly as well. By accepting our services, you are consenting to receive these communications.

It is your responsibility to provide our office with current phone numbers, mailing address and email address. Once we have generated four statements for unpaid balances with no payment, that account will be turned over to collections, even if it is due to inaccurate account information.

We accept cash, check and all major credit cards for account payments.



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PATIENT RIGHTS AND RESPONSIBILITIES

Patients of Duson Family Healthcare shall have the *right* to:

- Quality services, appropriate to their care needs which are delivered in a timely manner
- Be treated equally and receive care without regard to age, sex, religion, race or creed
- Confidentiality of his/her clinical records
- Be informed of all costs and expected payment from other resources
- Be treated with respect for individual patient's comfort, dignity, and privacy
- Be informed of his/her rights in advance of care being provided
- Obtain, from the practitioner, complete and current information concerning his/her diagnosis (to degree known, treatment, and any known prognosis)
- To inspect your medical records upon request, and to receive a copy for a reasonable fee
- Refuse treatment to the extent permitted by law

Patients of Duson Family Healthcare are *responsible* for:

- To give your health care provider correct and complete information about your present medical condition, chief complaint, past illnesses, hospitalizations, medications, including over-the-counter drugs/herbal supplements, and other health matters-including drug, alcohol, smoking and eating habits
- To provide your healthcare provider with accurate and updated demographic information such as address and phone numbers
- To follow the treatment plan and advise recommended by your health care provider
- To accept responsibility for your actions and decisions if you refuse treatment (or portions of recommended treatment) or do not follow the health care provider's complete instruction
- To meet your health care financial obligations promptly, including fees, co-pays, and deductibles
- To be considerate of the health care provider's other patients, personnel and property, and to treat them with respect and courtesy, as you would prefer to be treated
- To notify your PCP when you receive emergency care within twenty-four (24) hours, or as soon as possible



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ACKNOWLEDGEMENT OF RECEIPT

Name of Patient (PRINT)

- I acknowledge that I have been given the Duson Family Healthcare *Notice of Privacy Practices/Assignment of Benefits*. I certify that I have read and fully understand the statements in the policy and consent fully and voluntarily. This consent will remain in force until revoked in writing.
- I acknowledge that I have been given the Duson Family Healthcare *Financial Policy*, and I will be financially responsible for the above mentioned patient.
- I acknowledge that I have been given the Duson Family Healthcare *Patient Rights and Responsibility* policy.

Signature of Patient

Date

Signature of Patient Representative

Relationship to Patient



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**AUTHORIZATION FOR VERBAL RELEASE OF
MEDICAL/BILLING INFORMATION**

Patient Name

Date of Birth

I authorize Duson Family Healthcare to verbally disclose medical/billing information to the individuals listed below.

I agree to the verbal release of information from past, current, or future visits.

I agree that a photocopy of this authorization will be treated in the same manner as the original.

Information related to Mental Health, Chemical Dependency, or HIV testing and/or therapy will only be released to the patient.

Name of Individual	Relation to patient	Information to be disclosed (medical, billing)

This authorization will remain in effect until cancelled or revoked by patient. To cancel or revoke this authorization, I will forward a written notice to Duson Family Healthcare.

This information once released will no longer be protected under the Federal Privacy Laws.

Signature of patient/guardian

Date

Relationship to patient

Witness if pt is unable to sign

Date

Reason pt is unable to sign



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