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Patient Name Date of Birth

**HIPAA**

The Health Insurance Portability and Accountability Act (HIPAA), was created in 1996 by the US Congress to protect the privacy of patient’s health information. The act prohibits your healthcare provider from releasing your health care information unless you have provided with a HIPAA release form. Unless you have provided a signed release form, your health care providers are prohibited from discussing any aspect of your medical information with anyone who is not directly involved in your care. Please refer to Bethel’s Notice of Privacy Practices (available in paper copy at the receptionist desk or online) for a more complete description of such uses and disclosures.

**Release of Information**

I authorize the release of information including diagnosis, records, examination rendered to me, and claims information. The information may be released to:

* Spouse Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Children Name(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Do not release my medical information to anyone

*Note: This release of medical information will be in effect until terminated by you in writing.*

**Email Correspondence**

We will need to contact you regarding your personal healthcare information. This information includes test results, referral information, scheduling, canceling, or confirming appointments as well as any other medical information pertinent to your care. **We will NOT send you spam.** Our practice will use email as the primary means of contacting you, unless you specifically decline email communication. Please select an option below to communicate your preferences.

* Yes, please send me email correspondence to communicate with me regarding my personal healthcare information at: *Email Address* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* No, I do not wish to be emailed. I would only like to receive phone calls.

*Please Note:* By utilizing our services or replying to our emails, you acknowledge that you are aware that email is not a secure method of communication, and that you are aware of the risks. If you prefer not communicate via email, please specify above.

**Telephone Correspondence**

Please call: [ ] My cell #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] My home #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] My work #\_\_\_\_\_\_\_\_\_\_\_\_\_

If unable to reach me (check all that apply):

* You may leave a brief message asking me to return your call
* Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient’s Bill of Rights**

As a patient of Bethel Medical Center, you have the right to:

* Receive considerate, respectful and compassionate care in a safe setting regardless of your age, gender, race, national origin, religion, sexual orientation, gender identity or disabilities.
* Receive care in a safe environment free from all forms of abuse, neglect, or mistreatment.
* Be told by your healthcare provider about your diagnosis and possible prognosis, the benefits and risks of treatment, and the expected outcome of treatment.
* Expect full consideration of your privacy and confidentiality in care discussions, exams, and treatments.
* Be an active participant in your healthcare, including understanding and discussing various treatment options and test results. You have the right to accept or reject a treatment plan.
* Access your medical records.
* A second opinion; our healthcare providers will refer your case to another healthcare provider or specialist per request.

**Patient’s Responsibilities**

As a patient of Bethel Medical Center, you are expected to:

* Provide complete and accurate information, including:
  + Personal information (full name, date of birth, social security number, address, phone number, employer);
  + Insurance information; and, Medical and surgical history (current and past medical conditions, hospitalizations, surgeries, medicines, allergies, supplements, and any other matters that pertain to your health and safety).
* Ask questions when you do not understand information or instructions.
* Tell your healthcare provider if you believe you cannot follow through with your treatment plan.
  + You are responsible for your outcomes if you do not follow the care, treatment, and service plan prescribed.
* Be an active participant in your health.
* Keep appointments, be on time, and call the office if you cannot keep your appointments.
* Treat all staff, healthcare providers, other patients and visitors with respect; and, abide by practice policies and safety regulations.
* Be familiar with your insurance plan including your plan’s co-pay, deductible, and benefit package.
* Pay your bills in a timely manner.

**Patient Financial and Insurance Policy**

* The patient (or patient’s guardian, if a minor) is ultimately responsible for the payment for her treatment and care.
* We are pleased to assist you by billing for our contracted insurers. However, the patient is required to provide us with the most correct and updated information about their insurance, and will be responsible for any charges incurred if the information provided is not correct or updated.
* Patients are responsible for the payment of co-pays, co-insurance, deductibles, and all other procedures or treatment not covered by their insurance plan. Payment is due at time of service.
* Please be aware that Bethel will utilize the services of collections agencies for monies due for unpaid account balances after several attempts to collect payment.

**Appointment Cancellation, No-Show and Rescheduling Policy**

* Effective April 4, 2016 any **appointments that are not cancelled or rescheduled up to 24 hours in advance will result in a $25 charge billed to your account**. Cancellation fees are not billed to insurance.

*By my signature below, I hereby authorize assignment of financial benefits directly to Bethel Medical Center for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment. I agree that I have been fully disclosed of the practice’s HIPAA Privacy Policy, Email and Telephone Correspondence Policy, Patient Rights and Responsibilities, and Patient Financial and Insurance Policy.*

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Signature of Patient or Guardian Date of Service