Premier Family Medicine, LLC

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# Acknowledgement of Receipt

of Notice of Privacy Practices
Financial Policy
Lab / Test Policy

## HIPAA & Your Protected Health Information

Use and disclosure of Protected Health Information (PHI, aka Medical Records) in regulated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Under HIPAA, we are required to give patients our Notice of Privacy Practices for PHI and make a good faith effort to obtain a written acknowledgement that this notice was received. HIPAA also requires that adult patients specify to whom (if anybody) we may release their PHI.

**Pre-Authorized Release of Protected Health Information:**

You may authorize Premier Family Medicine (PFM) to release medical information to other individuals such as a spouse, child, neighbor, etc. Your signature authorizes PFM to release Protected Health Information (PHI) to the individuals listed below. This authorization will be effective for 18 months from the date of signature.

**Please tell us to whom we may release your PHI:**

## Financial Policy

Our Financial Policy is written on a separate page which you have received or may request. It outlines your financial responsibility as a patient. We will make every effort to work with you to ensure your insurance pays what they are responsible for. However, we can only bill your insurance company or Medicare for the services provided, for the reasons documented in your Medical Record. We cannot change billing codes just so insurance will pay. We must follow all applicable billing & coding laws. Unfortunately, some insurance policies do not pay for some visits.

## Lab / Test Policy

It is our policy to notify all patients of their lab and/or test results regardless of outcome. However, you are ultimately responsible for your own healthcare. Unfortunately, we are not always able to track when or if an individual patient has had a lab or test done. And, while the lab and testing facilities make every effort to forward your results to our office, we do not always receive them. **THEREFORE, if you do not receive a notice from us within two weeks of having a lab or test performed, you are responsible for contacting our office to obtain your lab or test results.**

**Acknowledgement**

I acknowledge that I have read the above Lab / Test Policy and that Premier Family Medicine has provided me with a written copy of its Financial Policy and its Notice of Privacy Practices for me to read on behalf of myself, my family and/or *(specify)*_____.

**Authorization of the Release of PHI**

I also authorize the release of my Protected Health Information to the Individual(s) listed in the box above for the next 18 months. I understand that I may rescind this authorization at any time with a written, signed and dated notice.

Signature:_____Date:_____

**To be completed by Premier Family Medicine, LLC**

We have made a good faith effort to provide the above named patient with a copy of our Notice of Privacy Practices, but were not successful for the following reasons:

| _____ | _____ | _____ | _____ |
|---|---|---|---|
| Printed Name | Title | Signature | Date |