Section 1: Understanding Your Rights & Responsibilities for Your Individual Health Information

Understanding Your Rights & Responsibilities for Your Individual Health Information
As an Advantia Health company, this physician practice is committed to protecting the privacy of medical information that we create or obtain about you. The Health Insurance Portability & Accountability Act, commonly known as HIPAA, is a federal law that sets forth your rights and responsibilities regarding how your personal information may be used in a document called the *Notice of Privacy Practices (NPP)*.

The electronic version of our *Notice of Privacy Practices* is available on our website. A hard copy of our NPP is available at the Front Desk of our offices.

Please read this document carefully and acknowledge your receipt of the document.

☐ I accept ☐ I decline

Please sign your full name below to accept the policy.

Patient Signature/Health Surrogate	Relationship	Date

Section 2: Consent to Call and Text

Modes of Communication
As a patient, you have the right to indicate how you would like for us to communicate with you and who (e.g., family members or friends) may receive information about your care.

Consent to Call
By signing below, the patient is giving permission for the practice to use the information provided as part of the check in process to email and call the patient.

This includes: Entry of any telephone contact number constitutes written consent to receive any automated, prerecorded, and artificial voice telephone calls and voicemail initiated by the Practice.

To alter or revoke this consent, visit the Patient Portal "Contact Preferences".

☐ I accept ☐ I decline

Consent to Text
Consent to Text indicates whether the patient has agreed to receive automated text alerts from the practice on their mobile phone. Depending on the features the practice offers, text alerts may be about appointments, test results, and more.

☐ I accept ☐ I decline

ADVANTIA HEALTH

Section 3: Communicating With Our Office

Home Phone Communication Preference

Indicate the type of communication that is acceptable to you by Home Phone.

☐ Calls/Voicemails ☐ None

Mobile Phone Communication Preference

Indicate the type of communication that is acceptable to you by Mobile Phone.

☐ Calls/Voicemails ☐ None

Release of Your Information to Other Parties

Check one of the below:

☐ I decline for the physician's office to leave confidential information with any person other than myself.

☐ I hereby authorize the release of confidential information pertaining to my health care, test results, procedures, billing, or accounting information to the persons listed below.

Name of First Individual	Relationship to Patient	Phone Number

Types of Information the individual is authorized to receive:

☐ Appointment Information
☐ Medical & Billing Information
☐ Prescriptions, Medical Records, X-rays, etc.

Name of Second Individual	Relationship to Patient	Phone Number

Types of Information the individual is authorized to receive:

☐ Appointment Information
☐ Medical & Billing Information
☐ Prescriptions, Medical Records, X-rays, etc.

This authorization or request remains valid until I submit a revocation or a new request in writing. I understand that the office will ask for identification of the person picking up medical information or products on my behalf.

☐ I accept ☐ I decline

Please sign your full name below to accept the policy.

Patient Signature/Health Surrogate	Relationship	Date

Section 4: Your Rights & Responsibilities as a Patient of Our Practice

What You Need to Know as a Patient

Treatment
I voluntarily consent to any and all health care treatment and diagnostic procedures provided by this practice and its associated clinicians and other staff members or any other satellite office that is under common ownership by Advantia Health.

I have the right to discuss my treatment plan with my clinician about the purpose, potential risks, and benefits of any test ordered for me. If additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s) being performed.

I am aware that the practice of medicine and other health care professions is not an exact science. I further understand that no guarantee has been or can be made as to the results of the treatments or examinations provided by this practice.

Medications/Prescription History
I give permission to obtain all of my medication/prescription history when using an electronic system to process prescriptions for my medical treatment.

Telehealth Visits
I agree to receive telehealth services when deemed appropriate and under the following conditions:

1. Telehealth involves the delivery of health care services (including assessment, treatment, diagnosis, and education) using interactive video, audio, or data communications;
2. I understand and agree that my clinician and I will not be in the same location or room;
3. My clinician and I will be able to speak with each other from remote locations, and if there are video capabilities, we will also be able to see each other;
4. Unless there is an approved exception, my clinician must be licensed in the state where I am receiving services, based on my physical location at the time of the telehealth visit. **Therefore, I have a responsibility to report my location during the registration of my telehealth appointment, and to advise my clinician of my actual location at the time of your telehealth appointment;**
5. If for some reason I change geographic location during my telehealth appointment, I have a responsibility to advise my clinician of my location change;
6. My clinician and I have a right to privacy during my telehealth session during which confidential information may be discussed, so I am responsible for ensuring privacy at my location, to include ensuring that any virtual assistant artificial intelligence devices, including but not limited to Alexa or Echo, will be disabled or will not be in the location where information exchanged during the telehealth visit can be heard;
7. To further maintain confidentiality, I agree that I will not share my telehealth appointment link or information with anyone not authorized to attend the session;
8. I have an obligation to notify my clinician of any other persons in the location, either on or off camera and who can hear or see your session;
9. I understand that I am responsible for information security on my device, to include phone, computer, tablet, and in my own location; and
10. I understand that a telehealth service is not an emergency service. In the event of an emergency, I am to use a phone to call 9-1-1 and/or other appropriate emergency services.

Needlestick/Exposure Control
I understand that my clinicians and other office staff are committed to my safety and their own. However, in the event that a medical test or treatment results in a staff member being exposed to my body fluids (e.g., blood), I agree to the testing necessary for the staff member's health.

Filming or Recording Interactions with Practice Staff
The filming or recording of my interactions with clinicians or other practice staff is strictly prohibited.

Appointment Cancellation & No-Shows
The appointment policy of this office requires me to contact the office **24 hours** before my scheduled appointment if I am unable to keep my appointment.

I understand that I will considered a "no show" if I fail to arrive for a scheduled appointment without notice. I may be charged a **$50 fee** if I am a "no show".

I will be considered a "same day cancellation" if I cancel the appointment less than 24 hours before my scheduled appointment.

If I have **3 or more "no shows" or "same day cancellations" I may be subject to dismissal from this physician office.**

If I fail to cancel a surgical procedure at least 24 hours in advance of the procedure, or I fail to show up for a surgical procedure, I may be subject to a **$100 no show fee**.

Insurance Assignment
I am responsible for providing accurate and complete insurance information to this physician office. If my insurance changes, I am responsible for promptly providing the updated information to this office.

I authorize payment of medical benefits to this practice or their designee by my insurance provider for services rendered to me.

I understand that if this practice does not accept the insurance that I have, I am personally responsible for all changes I incur. This office does not submit claims to insurance plans for which they are not an approved healthcare provider.

Responsibility for Payment for Services Received
If I am a self-pay patient, I understand that I will be required to pay for an office visit before services are rendered to me.

I understand that I am responsible for the payment of any co-payments, deductibles, and coinsurance at the time services are rendered to me.

Any unpaid balances that are overdue may be sent to a collection agency or an attorney.

I understand that this practice accepts the following forms of payment: VISA, MasterCard, Discover, and cash. The practice does not accept personal checks. If I provide a personal check that is returned, I will be charged a **$50 returned check fee**.

Request for Copies/Release of Medical Records
I have the right to obtain a copy of my medical record and to request the release of my medical records to another healthcare practice or group.

I must complete and sign an Authorization for Release of Medical Record form that I provide to the physician office to register my request.

I understand that I should allow at least two weeks for the physician office to acknowledge my request. If my request is of an urgent nature, I am responsible for communicating this urgency to the physician office.

I understand that I may be charged a fee for the copy of my medical record to include the cost of postage if applicable. The physician office will advise me of the approximate cost when I request my medical record.

The physician office is not responsible for a copy of my medical record that is lost in the mail or that is inappropriately accessed if the record is emailed to me.

Requirement to Follow Health Protocols During a Public Health Emergency
In the case of a public health emergency (such as COVID-19), I understand I must follow public health guidelines regarding the use of facial masks, social distancing, and advising the physician office of my symptoms or exposure to the disease.

Dismissal
I understand that my failure to adhere to the above policies may result in me being dismissed from the practice, with written notice provided to me by the physician office.

☐ I accept ☐ I decline

Please sign your full name below to accept the policy.

Patient Signature/Health Surrogate	Relationship	Date