VILLAGE
Pediatrics & Rheumatology

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Authorization & Acknowledgement of Practices Financial & Privacy Policies

In general, the HIPAA Privacy Rule (Health Insurance Portability & Accountability Act of 1996- a federal law) gives individuals the right to request a restriction of uses and disclosures of their Protected Heath Information (PHI). It also provides the right to request confidential communications between an individual and his/her physician's office. In order to protect your privacy and in keeping with the Federal Privacy Law, all of your medical information, PHI, is kept strictly confidential. We will use this PHI for Treatment, Payment, Operation (TPO) of our medical practice. We will be required to get an authorization in writing from you if we intend to use your PHI for any other purposes.

AUTHORIZATION

I authorize the release of any PHI necessary to determine liability for payment & to obtain reimbursement on any claim.

I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled, including, but not limited to, Medicaid, Medicaire, private insurances, and other health managment organizaton to the practice named on this form.

The assignments of benefits will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

I also give permisssion to the providers & nurses of Village Pediatrics & Rheumatology, LLC to treat, perform any diagnostic procedures, and to administer vaccines in the medical care of my child(ren).

I authorize Dr. Joan Calkins, and the practice staff to leave medical information pertaining to my care by the following methods; and I will assume the responsibility of notifying the office whenever this information changes.

Please indicate below how you would like our office to handle communicaitons with you.

APPOINTMENT INFORMATION:

- Home Phone (Include auto call)? ☐
- Mobile Phone (Include auto call)? ☐
- Mobile Text (Include auto call)? ☐
- Work Phone? ☐
- With Another Person? ☐
- Send via Mail? ☐

MEDICAL INFORMATION:

- Home Phone (Include auto call)? ☐
- Mobile Phone (Include auto call)? ☐
- Work Phone? ☐
- With Another Person? ☐
- Send via Mail? ☐

CONTACTS: OK to contact (Name, Relationship, Phone Number)

_____ _____ _____

_____ _____ _____

_____ _____ _____

I agree to the insurance assignments & financial responsibilities as indicated by Village Pediatrics & Rheumatology, LLC. I am also aware of my rights and practice's responsibilities with respect to Private Health Information (PHI) as outlined in Village Pediatrics & Rheumatology's Notice of Privacy Practices.

_____ _____ _____

Patient Name (Please Print) | Signature (Patient or Parent if Minor) | Date