NTMC Specialty Clinic/ Medical Care Center

LastName	FirstName	MiddleInitial

DateofBirth	SSN#	Driver'sLicense#	Marital Status:M SDW

Physical Mailing Address:	City:	State:	Zip:

Parent/LegalGuarding if patientisa Minor:

HomeNumber:	Cell Number:	WorkNumber:

LeaveVoice Message? Yes☐No☐	LeaveTextMessage? Yes☐No☐	Leave Texts and Voicemails In: Morning☐Afternoon☐Evening☐	Language: English☐Spanish☐Other☐

Email Address:	Race: Asian☐White☐Hispanic☐Indian☐AfricanAmerican☐Other☐

Occupation:	Employer's Name:	Are you a Veteran Yes☐No☐

Employer's Address:	City:	State:	Zip:

Spouse's Name	Spouse'sEmployer

Emergency ContactName:	Relationship:

Emergency Contacts Home#	EmergencyContacts Work#	EmergencyContacts Cell#
PharmacyName:	PharmacyPhone:	PharmacyAddress:
InsuranceCompany:	Policy#	Group#:
Subscriber's Name:	DateofBirth:	SSN#:

Patient Name:________________________________**DOB:**______________________**SSN#:**

____**CONSENT FOR TREATMENT FORM**

______ (Initial) I understand that I have presented myself to NTMC CLINICS for evaluation and/or treatment for a medical condition. I authorize and direct NTMC CLINICS to perform quality care upon me and understand that all options will be discussed prior to the administration of such treatment. I acknowledge that t the practice of medicine is no t an exact science and that no guarantees have been made to me as to the outcome of any procedures and/or treatments. I grant this consent without duress, confusion, o r pressure from my physician and /or his or her staff, associates, or colleagues.

FACSIMILEAUTHORIZATIONFORM

______ (Initial) I, the under signed, authorize NTMC CLINICS to send/ receive confidential healthcare information as the term is defined by HIPAA (HealthInsurancePortabilityandAccountabilityActof1996, 45C.F.R., Parts160-164) by facsimile to health ca re providers, hospitals, laboratories, and o the medical care givers in the necessary coordination of care for the patient listed. I may revoke this authorization by giving NTMC CLINICS five (5) days written notice. **This revocation may be by facsimile transmission; however, a written copy of the revocation must be mailed to NTMC CLINICS as well.**

ASSIGNMENT OF BENEFITS/FINANCIAL AGREEMENT

______ (Initial) I hereby give authorization of insurance benefits to be made directly to NTMC Clinics for services rendered. I understand that I am financially responsible for all charges that are not covered by my insurance. In the event of default, I agree to pay all costs of collection. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photo copy of this agreement will be as valid as the original.

ACKNOWLEDGEMENT OFPATIENT RIGHTS

______ (Initial) I have read the **NOTICE OF PATIENT RIGHTS** and have had any questions answered by this office. I understand that that by signing this form I acknowledge that I have read the Patient Rights Notice. My consent is freely given. I understand that I may revoke this consent at anytime if that revocation is in writing. But any disclosures given in reliance on this prior consent will be permissible.

ACKNOWLEDGMENT OF PATIENT RESPONSIBILITIES

______ (Initial) I have read the **NOTICE OF PATIENT RESPONSIBILITIES** and have had any questions answered by this office. I understand that by signing this form I acknowledge that I have read the **Patient Responsibilities Notice** posted in all NTMC CLINICS locations. My consent is freely given. I understand that I may revoke this consent at anytime if that revocation is in writing, but any disclosures given in reliance on this prior consent will be permissible.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

______ (Initial) I acknowledge that NTMC CLINICS has provided me with the opportunity to view and read a written copy of their ***NOTICE OF PRIVACY PRACTICES.***

DISCLOSURE OF PROTECTED HEALTH INFORMATION TO FAMILY MEMBERS & CONSENT OF DISCLOSURE OF INFORMATION

______ (Initial) I acknowledge that NTMC Clinics will disclose my Protected Health Information (PHI) to a family member, other relative, close friend or any other person I identify that directly relates to that person's involvement in my care.

People we can disclose your PHI to: **Relationship to self:**

____ ____

OR

_______ (Initial) **I OBJECT** to the disclosure of my **Protected Health Information** to a family member, other relative, close friend or any other person.

_______ (Initial) **SHARING OF INFORMATION FOR PURPOSE OF PAYMENT:** I acknowledge that NTMC Clinics will share all necessary information with my insurer(s), payer(s), governmental entities (such as Medicare, Medicaid, etc.) and their representatives (including, but not limited to benefit determination and utilization review) as well as your representatives involving in the billing process (including, but not limited to) claims representatives, data warehouses, billing companies. Sharing of information for purposes of operations: You will share all information necessary for ongoing operations of this office (including, but not limited to) the credentialing for ongoing operations of this office and any relevant processes, the credentialing processes, peer review, accreditation and compliance with all federal and state laws.

COMMUNICATION AUTHORIZATION

_______ (Initial) I acknowledge that NTMC Clinics may communicate with me via US mail, e-mail, and l and line home phone, through the patient portal, on cell phone and through text messaging.

ALTERNATIVE COMMUNICATION AUTHORIZATION

_______ (Initial) I request for an alternative method of communication such as alternative address or work phone number.

Alternative Method:____ DATE:

____Patient Signature: _______________

Personal Representative Signature: _________________ Relationship to Patient: ______________

(If applicable)

AGREEMENT Opt Out FORM

_______ (Initial) If I paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request. I request that the below service(s) not be disclosed to a health plan for purposes of payment or health care operations.

PRESCRIPTION POLICY CONSENT FORM

_______ (Initial) For non-narcotic prescription refills, I will give the office at least 24hours' notice I understand that if I do not sign the drug policy Conseco or refuse to submit for a drug test I could be dismissed from the practice. By initialing here, I also agree to give NTMC CLINICS to look up past medicines prescribed to me by this provider and any others.

No Show-Missed Appointments

For any reason you need to cancel an appointment please notion our office as soon as possible. On your second no-show occurrence, there will be a $25 charge to your patient account. After three consecutive no-show occurrences, the practice may elect to terminate our relationship with you.

1. *Cancellation/No Show Policy for Doctor Appointment*

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel, and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.
If an appointment is not cancelled at least24 hours in advance you will be charged a Twenty-five dollar ($25) fee; this will not be covered by your insurance company.

2. *Scheduled Appointments*

We understand that delays can happen however we must try to keep the other patients and doctors on time.
If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment.

3.*Cancellation/No Show Policy for Surgery*

Due to the large block of time needed for surgery, last minute cancellations can cause problems and added expenses for the office.
If surgery is not cancelled at least 10 days in advance you will be charged a seventy-five-dollar ($75) fee; this is will not be covered by your insurance company.

4. *Account balances*

We will require that patients with self-pay balances do pay their account balances to zero (0) Prior to receiving further services by our practice.
Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concerns.
Patients with balances over$100 must make payment arrangements prior to future appointments being made.

____/____/___
Print Name /Patient Signature/ Patient/Guardian Date

Patient Account #___________________
(Office Use Only)

Authorization for Use or Disclosure of Protected Health Information

Pt. Name: ____
SS#_____________________________________ DOB: ____________________________________
Daytime Phone#:______________________Evening Phone #: ________________________________
Address: ____
City: ________________________ State: ______________ Zip Code: _____________________________
I hereby authorize ________________________to use or disclose my protected health information as indicated below to:
Name: ____
Phone#: ____ Fax #: ______________________________
Address: ____
City: ________________________ State: ______________ Zip Code: _____________________________

Information to be released:

From & To Dates: ________________________

_____ Copy of complete records

_____ Information related to HIV testing results

_____ History and Physical/Consultation reports

_____ Laboratory, Xrays, PFT, Echo, Angio, OP reports

_____ Other
________________________________Purpose of Disclosure:

I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this form, I am specifically authorizing the release of information relating to:
_____ Substance Abuse (including alcohol/drug abuse
_____ Mental Health
_____ Psychotherapy Notes
_____ HIV related information (including AIDS related testing)

___________________________ ________________
Signature of Patient or Legal Guardian Date

_____Changing physician
_____Continuing Care
_____At my (patient) request
_____Workers' Compensation
_____ Second Opinion
_____ Legal
_____ Insurance
_____ School
Other: ______________________________

1. I understand that this authorization will expire two years from my last date of service visit. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying the Privacy Officer at the address indicated below in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specialty protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.
4. My health care and payment for my health care will not be affected if I do not sign this form.
5. I understand that I will get a copy of this form after I sign it.

By signing below, I acknowledge that I have read and understand this Authorization.

Signature: ___________________________ Relationship: ________________ Date: ____________
Patient or Representative

Witness: ______________________________ Date: _________________________

NOTICE OF PRIVACY PRACTICES
NTMC Clinics

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective Date: 03/01/2018
This Notice was revised on 03/01/2018

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE OR IF YOU NEED MORE INFORMATION, PLEASE CONTACT OUR PRIVACY OFFICER:

Privacy Officer: Practice Manager of "NTMC Clinics"
Mailing Address:
Telephone:
Fax:
Email:

About This Notice

We are required by law to maintain the privacy of Protected Health Information and to give you this Notice explaining our privacy practices with regard to that information. You have certain rights – and we have certain legal obligations – regarding the privacy of your Protected Health Information, and this Notice also explains your rights and our obligations. We are required to abide by the terms of the current version of this Notice.

What is Protected Health Information?

"Protected Health Information" is information that individually identifies you and that we create or get from you or from another health care provider, health plan, your employer, or a health care clearinghouse and that relates to (1) your past, present, or future physical or mental health or conditions, (2) the provision of health care to you, or (3) the past, present, or future payment for your health care.

WHO WILL FOLLOW THIS NOTICE?

✓ NTMC Clinic providers

✓ All NTMC Clinic employees

We understand that medical information about you and your health is personal and are committed to protecting this information. When you receive care at The Hand and Wrist Institute, a record of the care and services you receive is made. Typically, this record contains your treatment plan, history and physical, test results, and billing record. This record serves as a:

- Basis for planning your treatment and services;
- Means of communication among the physicians and other health care providers involved in your care;
- Means by which you or a third-party payer can verify that services billed were actually provided;
- Source of information for public health officials; and
- Tool for assessing and continually working to improve the care rendered.

This Notice tells you the ways we may use and disclose your Protected Health Information (referred to herein as "medical information"). It also describes your rights and our obligations regarding the use and disclosure of medical information.

OUR RESPONSIBILITIES.

NTMC Clinics shall:

- Make every effort to maintain the privacy of your medical information;
- Provide you with notice of our legal duties and privacy practices with respect to information we collect and maintain about you;
- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction; and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.
- NTMC Clinics will notify you, and the Department of Health & Human Services, of any unauthorized acquisition, access, use or disclosure of your unsecured medical information that presents a significant risk of financial, reputational or other harm to you, to the extent required by law. Unsecured medical information means medical information not secured by technology that renders the information unusable, unreadable, or indecipherable as required by law.

How We May Use and Disclose Your Protected Health Information

We may use and disclose your Protected Health Information in the following circumstances:

- **For Treatment.** We may use or disclose your Protected Health Information to give you medical treatment or services and to manage and coordinate your medical care. For example, your Protected Health Information may be provided to a physician or other health care provider (e.g., a specialist or laboratory) to whom you have been referred to ensure that the physician or other health care provider has the necessary information to diagnose or treat you or provide you with a service.
- **For Payment.** We may use and disclose your Protected Health Information so that we can bill for the treatment and services you receive from us and can collect payment from you, a health plan, or a third party. This use and disclosure may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, we may need to give your health plan information about your treatment in order for your health plan to agree to pay for that treatment.
- **For Health Care Operations.** We may use and disclose Protected Health Information for our health care operations. For example, we may use your Protected Health Information to internally review the quality of the treatment and services you receive and to evaluate the performance of our team members in caring for you. We also may disclose information to physicians, nurses, medical technicians, medical students, and other authorized personnel for educational and learning purposes.
- **Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services.** We may use and disclose Protected Health Information to contact you to remind you that you have an appointment for medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.

- **Minors.** We may disclose the Protected Health Information of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law. *(Optional, only included if applicable.)*

- **Research**. We may use and disclose your Protected Health Information for research purposes, but we will only do that if the research has been specially approved by an authorized institutional review board or a privacy board that has reviewed the research proposal and has set up protocols to ensure the privacy of your Protected Health Information. Even without that special approval, we may permit researchers to look at Protected Health Information to help them prepare for research, for example, to allow them to identify patients who may be included in their research project, as long as they do not remove, or take a copy of, any Protected Health Information. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research. However, we will only disclose the limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which it was provided, (2) ensure the confidentiality and security of the data, and (3) not identify the information or use it to contact any individual.

- **As Required by Law.** We will disclose Protected Health Information about you when required to do so by international, federal, state, or local law.

- **To Avert a Serious Threat to Health or Safety**. We may use and disclose Protected Health Information when necessary to prevent a serious threat to your health or safety or to the health or safety of others. But we will only disclose the information to someone who may be able to help prevent the threat.

- **Business Associates.** We may disclose Protected Health Information to our business associates who perform functions on our behalf or provide us with services if the Protected Health Information is necessary for those functions or services. For example, we may use another company to do our billing, or to provide transcription or consulting services for us. All of our business associates are obligated, under contract with us, to protect the privacy and ensure the security of your Protected Health Information.

- **Organ and Tissue Donation.** If you are an organ or tissue donor, we may use or disclose your Protected Health Information to organizations that handle organ procurement or transplantation – such as an organ donation bank – as necessary to facilitate organ or tissue donation and transplantation.

- **Military and Veterans.** If you are a member of the armed forces, we may disclose Protected Health Information as required by military command authorities. We also may disclose Protected Health Information to the appropriate foreign military authority if you are a member of a foreign military.

- **Workers' Compensation.** We may use or disclose Protected Health Information for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

- **Public Health Risks.** We may disclose Protected Health Information for public health activities. This includes disclosures to: (1) a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; (2) prevent or control disease, injury or disability; (3) report births and deaths; (4) report child abuse or neglect; (5) report reactions to medications or problems with products; (6) notify people of recalls of products they may be using; and (7) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

- **Abuse, Neglect, or Domestic Violence.** We may disclose Protected Health Information to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or

domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.

- **Health Oversight Activities.** We may disclose Protected Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, licensure, and similar activities that are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

- **Data Breach Notification Purposes.** We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose Protected Health Information in response to a court or administrative order. We also may disclose Protected Health Information in response to a subpoena, discovery request, or other legal process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may also use or disclose your Protected Health Information to defend ourselves in the event of a lawsuit.

- **Law Enforcement.** We may disclose Protected Health Information, so long as applicable legal requirements are met, for law enforcement purposes.

- **Military Activity and National Security.** If you are involved with military, national security or intelligence activities or if you are in law enforcement custody, we may disclose your Protected Health Information to authorized officials so they may carry out their legal duties under the law.

- **Coroners, Medical Examiners, and Funeral Directors**. We may disclose Protected Health Information to a coroner, medical examiner, or funeral director so that they can carry out their duties.

- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose Protected Health Information to the correctional institution or law enforcement official if the disclosure is necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

Uses and Disclosures That Require Us to Give You an Opportunity to Object and Opt Out

- **Individuals Involved in Your Care or Payment for Your Care.** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

- **Disaster Relief.** We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.

- **Fundraising Activities.** We may use or disclose your Protected Health Information, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications. If you do not want to receive these materials, please submit a written request to the

Privacy Officer.

<u>Your Written Authorization is Required for Other Uses and Disclosures</u>

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and
2. Disclosures that constitute a sale of your Protected Health Information.

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

<u>Your Rights Regarding Your Protected Health Information</u>

You have the following rights, subject to certain limitations, regarding your Protected Health Information:

- **Right to Inspect and Copy.** You have the right to inspect and copy Protected Health Information that may be used to make decisions about your care or payment for your care. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

- **Right to a Summary or Explanation.** We can also provide you with a summary of your Protected Health Information, rather than the entire record, or we can provide you with an explanation of the Protected Health Information which has been provided to you, so long as you agrees to this alternative form and pay the associated fees.

- **Right to an Electronic Copy of Electronic Medical Records.** If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format
you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

- **Right to Get Notice of a Breach.** You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

- **Right to Request Amendments.** If you feel that the Protected Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us. A request for amendment must be made in writing to the Privacy Officer at the address provided at the beginning of this Notice and it must tell us the reason

for your request. In certain cases, we may deny your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

- **Right to an Accounting of Disclosures.** You have the right to ask for an "accounting of disclosures," which is a list of the disclosures we made of your Protected Health Information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice. It excludes disclosures we may have made to you, for a resident directory, to family members or friends involved in your care, or for notification purposes. The right to receive this information is subject to certain exceptions, restrictions and limitations. Additionally, limitations are different for electronic health records. The first accounting of disclosures you request within any 12-month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the accounting. We will tell what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the Protected Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Protected Health Information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. To request a restriction on who may have access to your Protected Health Information, you must submit a written request to the Privacy Officer. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to your request, unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we do agree to the requested restriction, we may not use or disclose your Protected Health Information in violation of that restriction unless it is needed to provide emergency treatment.

- **Out-of-Pocket-Payments.** If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you only at your work number. You must make any such request in writing and you must specify how or where we are to contact you. We will accommodate all reasonable requests. We will not ask you the reason for your request.

- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time.

How to Exercise Your Rights

To exercise your rights described in this Notice, send your request, in writing, to our Privacy Officer at the address listed at the beginning of this Notice. We may ask you to fill out a form that we will supply. To exercise your right to inspect and copy your Protected Health Information, you may also contact your physician directly. To get a paper copy of this Notice, contact our Privacy Officer by phone or mail.

Changes To This Notice

We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for Protected Health Information we already have as well as for any Protected Health Information we create or receive in the future. A copy of our current Notice is posted in our office and on our website.

Complaints

You may file a complaint with us or with the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated.

To file a complaint with us, contact our Privacy Officer at the address listed at the beginning of this Notice. All complaints must be made in writing and should be submitted within 180 days of when you knew or should have known of the suspected violation. There will be no retaliation against you for filing a complaint.

To file a complaint with the Secretary, mail it to: Secretary of the U.S. Department of Health and Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201. Call (202) 619-0257 (or toll free (877) 696-6775) or go to the website of the Office for Civil Rights, www.hhs.gov/ocr/hipaa/, for more information. There will be no retaliation against you for filing a complaint.

Foreign Language Version

If you have difficulty reading or understanding English, you may request a copy of this Notice in Spanish

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient Name ________________________________Date of Birth_________________
Social Security Number ____

1. I acknowledge that NTMC Clinics has provided me with a written copy of their Notice of Privacy Practices. __________ (Initial)

2. I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions. __________ (Initial)

3. I acknowledge that ____________will disclose my Protected Health Information to a family member, other relative, close friend or any other person I identify that directly relates to that person's involvement in my care. __________ (Initial)

Person(s)_____________________________ ________________________
(Relationship) (Relationship)

OR

__________ I object to the disclosure of my Protected Health Information to a family
(Initial) member, other relative, close friend or any other person.

4. I acknowledge that ____________ may communicate with me via US mail, home phone number, or cell phone number. __________ (Initial)

5. I request for an alternative method of communication such as alternative address or work phone number. __________ (Initial)

Alternative method:____

____ ________________________
Patient Signature Date

____ ________________________
Personal Representative Signature (if applicable) Relationship to Patient

DO NOT FILE TO INSURANCE

Out-of-Pocket-Payments

Notifier(s):________________________________ Date: ___________________

Patient Name: _____________________________ Date: ___________________

If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

I request that the below service(s) not be disclosed to a health plan for purposes of payment or health care operations.

I understand that the below service will **NOT** be submitted to my insurance company for reimbursement by NTMC Clinics. I understand that the below service is considered self-pay and will be paid in full at the time of service to NTMC Clinics

Date of Service____
Service(s)____
Amount of service(s) paid in full $_____________________________________

Signature: ___________________________________ Date: ___________________