North Shore Internists Physicians

HIPAA PATIENT ACKNOWLEDGEMENT

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this form. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do we shall honor that agreement.

By signing this form you acknowledge receipt of North Shore Internist Physicians Notice of Privacy Practices.

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has received a copy of this document
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- Authorize North Shore Internists Physicians to electronically prescribe and retrieve prescription history from a preferred pharmacy

_____ _____

Printed Name - Patient or Representative Signature of Patient or Representative

Date _____

Please complete the following information with regards to our ability to leave a detailed message or speak with another person on your behalf.

Please indicate where we may leave a message **by preference 1,2,3**,

Home _____ Number_____ Work ____ Number _____

Cell _____ Number_____

If authorized, to whom may we release information about your health? No one but me _____ Alternate_____

Name of alternate _____ Relationship _____ Phone #_____

Name of alternate _____ Relationship _____ Phone #_____

PLEASE COMPLETE OTHER SIDE

Financial / Office Policies

Insurance: Please bring your insurance card with you to each visit. Without an insurance card you will be considered a self pay and payment will be due at the time of service.

Co-pays/Deductibles: These are fees that are agreed upon by you and your insurance company. When a co-pay or deductible applies you will be expected to pay that amount at time of service. A $10.00 billing fee will be added for all co-pays/deductibles not paid at time of service.

HMO insurance: We do not participate in any HMO products. If you choose to be seen by a physician at North Shore Internist Physicians you will be paying out of pocket as a self pay patient.

Wellness Plans/Medical Insurance plans: It is your responsibility to know your insurance and whether you have a wellness plan. If you do not advise us that the appointment is a routine wellness physical we will bill your insurance company as a medical exam. We adhere to the guidelines of the wellness plans. If an abnormality or preexisting problem is addressed during your routine physical there will be an additional code filed to your insurance company which would then fall under the deductible and co-payment guidelines.

No Show or Late Cancellations: If you are unable to keep your appointment kindly give us 24 hours notice. There will be a $75.00 fee for a late cancellation or for not showing up for your appointment. Exceptions will be made for true emergencies.

Motor Vehicle Accidents: We do not file to your insurance company. You are responsible for payment at the time of service. We will supply you with the information to recoup the fee from your insurance company.

Workers Comp Claims: Will be treated as a self pay patient unless you supply us with your company's insurance company, a claim number and a contact person.

Medicare no secondary insurance: Patient is responsible for the 20% not covered by Medicare at time of service.

Prescription Refills: Refills will only be given during regular office hours with a 72 hour advance notice.

Phone Calls during business hours: Will be returned in order of urgency. All calls will be returned within 24 hours.

Sick Calls: If you are ill or there is an emergency we are available 24 hours a day. Please be aware that if you are ill, you need to be examined, as there is no substitute for a physical assessment. Prescription medications, including antibiotics, will not be prescribed without an examination. If the office is closed and you cannot wait until the office is open you may contact the physician on call by calling 847-635-5000 and following the prompts. In a true emergency call **911**.

Lab/Test results: You will be notified of your results within 7 business days. If you do not hear from us within 7 days please call the office.

Chart Copying: If you are requesting a copy of your chart, please fill out a formal request and allow 30 days for your copy. There is a copy fee based on the amount of pages. Our medical records department will advise you of the charges. We will call you when your records are ready.

Forms: There will be a $25.00 fee for filling out any types of forms with the exception of a wellness form.

Financial Assignment and Agreement:

1) Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance. If your insurance company does not pay their portion within 60 days you will become responsible for payment. A late fee of $10.00 will be added to your monthly statement until your balance is paid in full. In the event your account is turned over to a collection agency, you will be responsible for the balance on your account plus the service charges for the collection agency.

2)I request that payment of authorized Medicare and or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.

3) This assignment 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 approved or paid by said insurance.** I hereby authorize said assignee to release all information necessary to secure payment.

Signed (patient/parent if minor) _____ **Date** _____

PLEASE COMPLETE OTHER SIDE