

PATIENT HIPAA ACKNOWLEDGEMENT AND CONSENT

I understand that under the Health Insurance Portability and Accountability Act of 1996(HIPPA), I have certain rights to privacy regarding my protected health information.

I understand that this information can and will be used to:

- o Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- o Obtain payment from designated third-party payers.
- o Conduct normal health care operations such as quality assessments or evaluations and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information (available in the office in print form).

I have reviewed such Notice of Privacy Practices prior to signing this consent, and acknowledge that I have studied the Privacy Practices prior to signing this consent, and acknowledge that I have studied the Privacy Practices.

I understand that this organization has the right to change its Notice of Privacy Practices from time to time, and that I may contact this organization at any time at the address above to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or health care operations.

I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

\_\_\_\_\_  
Patient Name (Please Print)

\_\_\_\_\_  
Patient DOB

\_\_\_\_\_  
Patient (Or Legal Guardian) Signature

\_\_\_\_\_  
Date

**BILLING, PAYMENT AND REFUNDS**

- > All balances are due within 14 days of your statement date.
- > If you cannot pay the balance in full within 14 days of the statement date, please contact our office to see if you qualify for special payment options.
- > It is your responsibility to notify the office of any change in address, telephone number, employment and insurance coverage.
- > If you make an overpayment on your account, we will issue a refund only if there are no other outstanding debts on other accounts with the same guarantor or financial responsible party.
- > We reserve the right to put your account in a collection program, report delinquent accounts to credit bureaus, assess a collection fee for you up to 40% of the outstanding balance, take other collection action, and/or terminate you as a patient from this practice. In addition, if legal action is taken you will be responsible for the costs, which may be up to \$250.00/hour.

**LATE CANCELLATION/NO SHOW POLICY**

- > **5 business days** notice is required to cancel/reschedule an appointment otherwise a **\$100.00 late cancellation/no show** fee will be added on the patient account.
- > 3 appointment violations will result in discharge from the practice.

**GOOD BEHAVIOR CONTRACT**

- > All patients should abide with good behavior in all dealings with office providers and staff. Using verbal/physical violent behavior, profanity, racial remarks, and/or any other form of disrespectful behavior towards the office staff and/or provider will result in immediate termination from the practice.

**I have read and agree to all the above Practice Policies.**

\_\_\_\_\_  
Patient Name (Please Print)

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Signature, Patient or Legal Guardian

\_\_\_\_\_  
Date

**PERMISSION TO VERBALLY DISCUSS PROTECTED HEALTH INFORMATION**

Patient Name		Date of Birth	
Patient Address	City	State	Zip
Preferred Telephone	Work Telephone (Optional)		

- I give permission to Sarasota Primary Care, LLC to leave a voicemail for me at the Preferred Telephone number above.
- I give permission to Sarasota Primary Care, LLC to VERBALLY discuss medical information about me with (optional):

Name	Relationship
Home/Cell Number	Work Phone
Check all boxes that apply:	
<input type="checkbox"/> Scheduling / Appointment information <input type="checkbox"/> Medical Information including my symptoms, diagnosis, medication and treatment plan. <input type="checkbox"/> Behavioral Health information including my symptoms, diagnosis, medication and treatment plan. <input type="checkbox"/> Chemical dependency information including my symptoms, diagnosis, medication and treatment plan. <input type="checkbox"/> Billing and payment information. <input type="checkbox"/> Other (describe): _____	

- I give permission to Sarasota Primary Care, LLC to VERBALLY discuss medical information about me with (optional):

Name	Relationship
Home/Cell Number	Work Phone
Check All Boxes That Apply:	
<input type="checkbox"/> Scheduling / Appointment information <input type="checkbox"/> Medical Information including my symptoms, diagnosis, medication and treatment plan. <input type="checkbox"/> Behavioral Health information including my symptoms, diagnosis, medication and treatment plan. <input type="checkbox"/> Chemical dependency information including my symptoms, diagnosis, medication and treatment plan. <input type="checkbox"/> Billing and payment information. <input type="checkbox"/> Other (describe): _____	

I have the right to change or revoke my permission in writing at any time except where Sarasota Primary Care has already made disclosures in trust of this original request. I understand that I must complete a new form or notify Sarasota Primary Care in writing if I want to change or revoke any of the permissions indicated above.

Patient Name (Please Print) \_\_\_\_\_

Date of Birth \_\_\_\_\_

Patient/Legal Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

# Sarasota Primary Care

3131 Clark Rd, Sarasota, FL 34231

Office phone: (941) 922-1400

I authorize Sarasota Primary Care to charge my credit card with any payment due for my visit the day before the visit and/or any balance on my account.

CC #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

CV Code: \_\_\_\_\_ Billing ZIP Code: \_\_\_\_\_

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CC #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

CV Code: \_\_\_\_\_ Billing ZIP Code: \_\_\_\_\_

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CC #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

CV Code: \_\_\_\_\_ Billing ZIP Code: \_\_\_\_\_

Print Patient Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_