NOTICE of PRIVACY PRACTICES

A copy of ***Independence Physician Management's*** HIPAA Notice of Privacy Practices are posted in the main lobby and available for me to read in its entirety. The HIPAA Notice of Privacy Practices contains information on the uses and disclosures of my protected health information ("PHI").

DISCLOSURE of PROTECTED HEALTH INFORMATION and EMERGENCY CONTACT

I authorize ***Independence Physician Management*** to communicate with the following individuals about my medical condition, diagnosis, treatment, appointments (past and future), and financial obligation. I understand medical information may be withheld from individuals, including family members, unless I list them by name below.

Name: _____ **Relationship** _____

Name: _____ **Relationship**_____

I authorize ***Independence Physician Management*** to leave voicemail or answering machine messages regarding test results or other healthcare related concerns at my home or cell phone number. ☐ Yes ☐ No

Emergency Contact: _____ **Phone number**_____ **Relationship:** _____

Email Address: _____

FINANCIAL POLICY and AUTHORIZATION for ASSIGNMENT of BENEFITS

Independence Physician Management strives to make our financial policy, insurance filing, and billing process for our patients as simple as possible. It is your responsibility to make sure we have your correct insurance information and also your responsibility to know your co-pay, co-insurance amount and deductible. For Self-Pay patients, payment must be made at the time of service, and a 50% discount is offered to those patients. Patients will be assessed a $30 fee for checks returned due to Insufficient Funds. Statements are mailed out each month. Please contact our Central Billing Office for questions or concerns regarding your balance. ***Independence Physician Management*** will submit claims to my primary and secondary insurance directly for their services. I authorize payment directly to ***Independence Physician Management*** of any insurance benefits otherwise payable to me. Charges deemed as non-covered by insurance company are the responsibility of the patient except as required by law for State and Federal reimbursement programs. I authorize ***Independence Physician Management*** to release or receive any information necessary to expedite insurance claims.

GENERAL CONSENT for EXAMINATION and TREATMENT

I hereby consent and authorize ***Independence Physician Management*** to perform medical examinations and provide routine medical care for all my visits. This may include routine diagnostic and laboratory procedures and tests, medication administration, and other routine care for which a specific informed consent form will not be signed by me. This consent includes consent and authorization to photograph or otherwise take images of me and/or parts of my body for purposes of identification, diagnosis, treatment, payment and healthcare operations of ***Independence Physician Management***. Any photographs or other images taken will become part of my medical record. ***Independence Physician Management*** will not use such photographs or images for any other purposes without my specific written consent. I understand that certain procedures will require a specific informed consent, and that ***Independence Physician Management*** will provide me with information and forms prior to such procedures. . I grant ***Independence Physician Management*** consent to submit immunizations administered to State Immunization Registry; and to view and/or import all medication history prescribed within the last two years. I authorize ***Independence Physician Management*** to search and access my records through a Health Information Exchange (HIE) for purposes of medical treatment. I have the right to opt-out at any time by notifying ***Independence Physician Management***.

This form expires 3 years from today's date.

_____ _____

Patient's Name (Please Print) Signature

_____ _____

Patient Representative (If patient is unable to sign) Signature