NORTH TEXAS
ENDOCRINE CENTER

AUTHORIZATON TO DISCLOSE MEDICAL/FINANCIAL INFORMATION

Patient Name:_____________________________ Date of Birth:________________

Federal privacy guidelines (Health Information Portability & Accountability Act), commonly known referred to as "HIPAA", prevent this practice from disclosing protected health information (PHI) to anyone other than the patient. By signing this form, you are allowing us to communicate with designated individuals regarding your medical and financial records with this facility. Authorization is not required for disclosures that are necessary for your care, such as to other physicians and insurance companies for billing purposes. This authorization means yo are giving us permission to discuss your medical/financial information with people such as a spouse, adult children, other family members, caretakers, or anyone else you would like it shared with if necessary.

I, the undersigned, acknowledge that I have been offered a copy of the "Notice of Privacy Practices" for this facility and hereby authorize this facility to disclose PHI from my medical or financial records to the following person/people (example: family members).

Name:_________________________________ Relationship:__________________________

Type of information: (circle one) Medical Financial Both

Name:_________________________________ Relationship:__________________________

Type of information: (circle one) Medical Financial Both

Name:_________________________________ Relationship:__________________________

Type of information: (circle one) Medical Financial Both

This authorization is given freely with the understanding that:

1. I may revoke this authorization in writing at any time, but not retroactively.
2. North Texas Endocrine Center, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the information I have authorized.

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Patient Printed Name Patient Signature Date

Declination

I **do not** want any of my medical or financial information disclosed to other persons.

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Patient Printed Name Patient Signature Date

NOTICE OF PRIVACY PRACTICES

I understand that as part of my healthcare, North Texas Endocrine Center originates and maintains health records describing my health, symptoms, examination, test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

The North Texas Endocrine Center "Notice of Privacy Practices" provides specific information and complete description of how my personal health information may be used and disclosed. I have been provided access to the "Notice of Privacy Practices" dated April 14, 2003 and understand that I have a right to review the notice prior to signing this consent (if you would like an actual copy, please ask when you check in). I understand that North Texas Endocrine Center reserves the right to change the "Notice of Privacy Practices". I understand that I have a right to restrict the use and/or disclosure of my personal health information for treatment, payment, or healthcare operations and that North Texas Endocrine Center is not required to agree to the restrictions requested. I may revoke this consent at any time in writing except to the extent that North Texas Endocrine Center has already taken action in reliance on my prior consent. This consent is valid until revoked by me in writing.

Unless I request the contrary, in writing, I will receive appointment reminders on my home and/or mobile telephone answering system and/or appointment reminder cards by mail, whichever is the policy of North Texas Endocrine Center.

__________I request the following restrictions on the use and/or disclosure of my personal health information:

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I further understand that any and all records, whether written, oral, in electronic format are confidential and cannot be disclosed without prior written authorization, except as otherwise provided by the law.

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Patient Printed Name   Patient Signature   Date

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Witness Printed Name   Witness Signature   Date

NORTH TEXAS
ENDOCRINE CENTER

PAYMENT POLICY/RESPONSIBILITY STATEMENT

It is important that we have a good understanding with our patients regarding financial responsibility. We hope this summary will be helpful toward that end. We encourage you to discuss it with us and ask questions if necessary.

Cancellations and Missed Appointments:

Existing patients who miss an appointment or cancel with less than 24 hours of notice will be charged a cancelation fee of $25.

New patients who miss an appointment or cancel with less than 24 hours of notice will be charged a cancelation fee of $50.

These fees must be paid before another appointment can be scheduled.

Self Pay:

Payment is due at the time of service unless previous payment arrangements have been made. We offer a discount for all self-pay patients paying in full at the time of service.

Insurance:

We participate in many major insurance plans, including traditional Medicare. If you are not insured by a plan we do business, payment in full is expected at each visit. If you are insured by a plan we do business with, but you cannot provide us with an up-to-date insurance card, payment in full for each visit is required at the time of service. Please contact your insurance company with any questions you may have regarding your coverage. Knowing your insurance benefits is your responsibility.

CoPayments, Co-Insurance, and Deductibles:

All co-payments, co-insurance amounts and deductibles must be paid at the time of service unless other arrangements have been made. Copayments are a part of your contract with your insurance company.

Non-Covered Services:

Please be aware that some of the services you receive may be non-covered or not considered reasonable or necessary by your insurance company. You will remain responsible for amounts and any services that are not covered by your insurance company.

Claim Submission:

After your appointment, we will submit a claim to your insurance company. We will help you in any way we reasonable can to get your claims paid by the insurance company upon request. Please be aware that any remaining balance of your claim not paid by the insurance company is your responsibility. If your insurance carrier has not paid our claim within 90 days, we will expect payment from you.

Acceptable Forms of Payment:

For your convenience, we accept payment by cash, personal check (with valid driver's license), Visa, MasterCard, Discover, and American Express.

Responsibility Statement: Your insurance is a method for you to receive reimbursement for fees you have paid to the physician for services rendered. Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based on our contract with them. It is your responsibility to pay the deductible, co-insurance, and other balances not paid by your insurance company. We will assist you in receiving reimbursement as much as possible, but you are responsible for your bill. It is also your responsibility to inform the office anytime there is a change in your insurance coverage. **To ensure good billing practices, you will be asked to present a copy of your current insurance card and picture identification at each visit.**

Non-Medicare Patients: I authorize the release of all medical information necessary to process my claims I assign all medical and/or surgical benefits, including major medical benefits for which I am entitled, to North Texas Endocrine Center and its physicians. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Medicare Patients: I authorize any holder of medical information about me to be released to health care financing administration and its agents any information needed to determine benefits or benefits payable for related services. This assignment is to be considered in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I have read and understand the Payment Policy and Responsibility Statement as written above.
I agree to be financially responsible for all charges.

Patient Printed Name   Patient Signature   Date