Kimberly C. Stone & Amy Huber, PA-C
3701 S. Clarkson St. Suite 320, Englewood, CO 80113
P: 303.740.4883

HIPAA Consent and Financial Policy

Patient Name: ______________________________ **DOB: _____________________**

HIPAA: The practice provides this information to comply with the Health Insurance Portability and Accountable Act of 1996 (HIPAA). Our Notice of Privacy Practices provides information about how we may use and disclose protected information about you. The Notice contains a Patient Rights section describing your rights under the law. By signing below the patient understand:

- Protected health information may be disclosed or used for treatment. Payment or health care operations.
- The patient has the right to review and request a copy before signing. (Please ask our staff if you wish to review or obtain a copy of our Privacy Practices.)
- The patient has the right to restrict the use of their information. But the practice does not have to agree to those restrictions.
- The Practice may condition receipt of treatment upon the execution of this consent.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.

Release of Information: Besides myself, I authorize this practice to discuss personal medical information with the following person (s):
________________________________**and/or**_________________________________

Messages May be Left: (regarding appointments and call back information only) **Yes___ No___**

Check all that are authorized: ____**Home answering machine** ____**Email** ____**Cell** ____**Work**

Insurance and Assignment of Benefits: I hereby authorize this practice and its providers to apply for benefits on my behalf for covered services rendered. I further authorize the release of any necessary information, including medical information for this or any related claim, to my insurance carrier (or in the care of Medicare Part B benefits to the Social Security Administration and Health Care Financing Administration). A copy of the authorization may be used in place of the original. The authorization may be revoked by either me of my insurance carrier at any time in writing. I hereby authorize payment of all medical benefits to be paid directly to this practice and/or its providers for the services rendered. I understand and agree that I am financially responsible for the charges not paid by my insurance carrier. I understand that in certain instances my insurance may decide the medical services are not medical necessary and that payment may be denied for these services. I agree to be personally and fully responsible for the payment of any denied charges. If I have Medicare, I understand that I may be asked to sign an advanced notice/waiver for certain services or procedures.

I hereby certify that the information I have provided is correct. I hereby certify that I have read, understand and agree with the above HIPAA and financial policies. I further agree to pay bank charges for insufficient funds, finance charges and/or collection fees assessed to my account for any overdue balances.

Patient Signature/Legal Representative: ________________________________ Date: ______________