**North Franklin Internal Medicine & Pediatrics**

**Privacy Practices Acknowledgement Form**

I understand that under the Health Insurance Portability and Accountability Act (HIPAA) I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: Conduct, plan, and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment; directly and indirectly. Obtain payment from third party payers. Conduct normal healthcare operations such as quality assessments and physician certifications.

North Franklin Internal Medicine & Pediatrics is committed to ensuring that your privacy is protected. Should we ask you to provide certain information by which you can be identified, then you can be assured that it will only be used in accordance with this privacy statement.

North Franklin Internal Medicine & Pediatrics may change this policy from time to time and any person may contact this organization at any time to obtain a current copy of the notice of privacy practices.

**Our Office Policies:   
Communications regarding my accounts**: Until my accounts are finally settled, I give my direct consent to receive communications regarding my accounts from any servicers and any collectors of my accounts, through various means such as 1. Any cell, landline, or text number that I provide, 2. Any email address I provide, 3. Auto dialer systems, 4. Voicemail messages and other forms of communications.

**Co-pay, Unmet deductible, Unpaid balances:** Please note that it is our office policy to collect all co-pay amounts, unmet deductibles and unpaid balances prior to you being seen by our providers. I also understand that I am fully responsible for any additional fees related to the collection of my account(s). I understand that I will be charged a $25.00 billing fee for every month that my account remains unpaid.

**Appointment Policy:** Should you need to cancel or reschedule an appointment we ask that you advise us a minimum of 24 hours in advance of your scheduled appointment. Failure to notify the office will result in a $35.00 charge to your account on the second no show and every additional one after.

**Medical Records Transfer:** It is our office policy to transfer records as a courtesy to another doctor’s office, should you choose to leave the care of our providers. If you choose to have the records released to you, as the patient, we will provide up to 100 pages free of charge and anything over 100 pages is a $35.00 charge.

**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. I have been given the right to review such notice of privacy practices prior to signing this consent. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you agree then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.**

**I further understand that you may contact me by telephone to remind or notify me of appointments.**

**I acknowledge receipt of North Franklin Internal Medicine & Pediatrics privacy practices. I understand that NFIMP reserves the right to change the privacy notice at any time and that a copy of the revised notice will be made available to me.**

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Signature of Patient/Guardian Date Signed