Valencia Center For Women's Health

23823 Valencia Blvd., Suite 140, Valencia, CA 91355
Phone: (661) 290-3337 • Fax: (661) 253-3756

www.NaviMD.com

Welcome to Our Practice

Thank you for choosing **Valencia Center for Women's Health** for your OBGYN needs. We all are committed to enhancing the quality of your care and overall experience with us. One way of achieving this is by establishing clear communication regarding our policies and clear expectations of compliance with them.

The following information is provided to help you understand how your insurance works and what your responsibilities are. Please refer to our "Financial Policy" for further information regarding our financial policies.

We encourage you to contact the front office with any concerns you may have.

Healthcare Information & Patient Responsibility

It is the responsibility of patients to immediately communicate healthcare information to our office. Healthcare information includes the following:

- ❑ **Insurance information/coverage**
- ❑ **Authorization & Referrals**
- ❑ **Responsible financial person/party**
- ❑ **Address**
- ❑ **Telephone number**
- ❑ **Fax/Email**
- ❑ **Emergency contact**
- ❑ **Change of referring and, or primary care physician**

What to Expect At Each Visit

Please note that regardless of the status of your insurance, each time you arrive for your scheduled office visit, you will be expected to check-in, present your insurance card or any other relevant documents to the front desk before being seen by your provider.

Please contact the front desk if you have any questions or concerns. We are happy to assist you in any way we can.

Terms and Definitions

Deductible: A deductible is the initial amount of money an insured has to pay (out-of-pocket) before any benefits from the health insurance policy can be used. Most deductibles renew on an annual basis and begin in January with services covered under the calendar year. However, there are others that renew mid-year, in July. Some insurance carriers allow for a "last quarter carry-over" whereby services during the last quarter of a year can be carried over and applied to the next year's deductible. If you are unsure which you have, contact your insurance agent.

Co-Payment: A co-payment is a *fixed amount* you are required to pay for each medical service you receive, regardless of the cost of the service. Unlike a deductible that's usually paid once a year, a co-pay is paid *each time* a healthcare service is used.

Co-Insurance: Unlike the fixed amount of a copay, coinsurance is a percentage of the provider's cost of service after the deductible has been met.

Co-insurance continues to be paid until you reach your "out-of-pocket" maximum. After that, the insurance company will pay for all covered services up to the policy's maximum, for the remainder of the year. Out-of-pocket maximums have a wide range of possibilities depending upon the insurance - from $500 to $1,000 or more.

Out-of-Network: A Provider who has not contracted with your insurance company for reimbursement at a

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negotiated rate, is referred to as an "out-of-network" provider.

Some health plans (example, HMOs) do not reimburse out-of-network providers at all, which means that as the patient, you would be responsible for the full amount charged by your doctor.

Other health plans offer coverage for out-of-network providers, but your patient responsibility would likely be higher than it would be if you were seeing an in-network provider.

Your Privacy

- We respect & protect the privacy of all our patients
- Federal law - Health Insurance Portability and Accountability Act (HIPAA) - protects the handling, storing, and release of your healthcare information.
- For more information regarding your privacy rights, please contact the Office Manager.

We look forward to providing you the best service possible.

Sincerely,

Providers & Staff of
Valencia Center for Women's Health

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REGISTRATION FORM

PATIENT INFORMATION

Patient's last name:	First:		Middle:	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Social Security No.: / /	Age:	Date of Birth: / /	Home phone No.: ( )	Cell phone No.: ( )	
Street address:		City:	State	ZIP Code:	
Occupation:	Employer:		Employer phone No.: ( )		
If patient is a minor, please provide parent/guardian names and specify relation to the patient:					
Referred to clinic by (please check one box):		❑ Dr. Name:			
❑ Family	❑ Friend	❑ Web Search	❑ Insurance Plan	❑ Hospital	❑ Other

eMail:

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship:	Home phone No.: ( )	Work phone No.: ( )
Street address:	City:	State	ZIP Code:

INSURANCE INFORMATION

(Please give your insurance card(s) to the receptionist)

Name of Primary Insurance:					
Subscriber's name:		Birth date: / /	Group No.:	Policy No.:	Co-payment: $
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
Name of Secondary Insurance (if applicable):					
Subscriber's name:		Birth date: / /	Group No.:	Policy No.:	Co-payment: $
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

GUARANTOR INFORMATION

If the patient is responsible for his/her bill, please skip the next section.

The guarantor is the person responsible for the patient's bill. If the patient is a minor (under the age of 18), the parent or guardian bringing the patient to the visit is usually the guarantor for the patient.

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone No.: ( )	
Occupation:	Employer:	Employer address:	Employer phone No.: ( )	

PHARMACY

Pharmacy name:	Pharmacy Address:	Phone No.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize **VALENCIA CENTER FOR WOMEN'S HEALTH** or insurance company to release any information required to process my claims.

Patient/Guardian signature / / ***Date***

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Financial & Payment Policy

Thank you for choosing us as your health provider. We believe that good care for you and your family starts with good communication, and we have created this policy to help our patients understand their financial responsibilities. If at any time you have questions, please ask us. Please sign below after reading this policy. A copy will be provided to you upon request.

1. **Payment for service.** Payment is due at the time of service unless other arrangements have been made. We gladly accept most major credit cards including Visa, MasterCard, and personal checks or cash. Ask us about other financial arrangements available.
2. **Insurance Coverage.** We participate in most major insurance plans. If you are not insured by a plan that we are a provider for, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
   a. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. To confirm your insurance eligibility, please provide us with a copy of your driver's license and current valid insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.
   b. **Coverage changes.** If your insurance changes, please notify us immediately so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in **45 days**, the balance may automatically be billed to you.
3. **Out-of-Pocket Responsibility**: In some cases, our fees may be adjusted based on whether we participate in or accept insurance or government program payments, allowances, or limitations. But, if we present a charge to you, it means that we have taken any such adjustment into account and that you must still pay the amount remaining. If you are reimbursed directly by a program for the cost of your care, you must still pay our charges promptly, whether or not you have received that reimbursement. If you do not agree with patient responsibility amounts or reimbursement amounts set by your insurance or government program, this is a matter between you and that program. We are happy to provide you with factual information about your care and billing to help you discuss this with them, but we still require you to promptly pay the entire charge we present to you, even if your issue with the program is not resolved.
   a. **Copayments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
   b. **Non-covered services.** Please be aware that some--and perhaps all--of the services you receive may be non-covered or not considered reasonable or necessary by your insurance plan. You must pay for these services in full at the time of visit.
4. **Claims submission.** As courtesy to you, we will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
5. **Nonpayment.** If your account is over **60 days** past due, you will receive a letter from us or our agents stating that you have **20 days** to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have **30 days** to find alternative medical care. During that **30-day period**, your doctor will only be able to treat you on an emergency basis.
6. **Missed appointments.** Our policy is to charge a fee equal to **$90 for missed appointments** NOT canceled or rescheduled prior to 48 hours of your scheduled appointment. This will allow more availability for patients who desire to be seen. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.
7. **Returned Checks.** All returned checks will be subject to an external collection service and a **collection fee of $25**. In addition, to cover the cost for returned checks, you will be charged an **administrative fee of $25** (which includes the bank penalty charges incurred) and the cost of certified mailing in the addition to the amount of your returned check amount.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read the above. I fully understand and accept the terms and conditions set forth.

Signature of patient or responsible person: _____

Print Patient Name: _____ Date: _____

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ASSIGNMENT OF BENEFITS

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to **Valencia Center for Women's Health** for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize **Valencia Center for Women's Health** to:

1) Release any information necessary to insurance carriers regarding my illness and treatments;
2) Process insurance claims generated in the course of examination or treatment; and
3) Allow a photocopy of my signature to be used to process insurance claims for the period of lifetime.

This order will remain in effect until revoked by me in writing.

I have requested medical services from **Valencia Center for Women's Health** on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

I have read and agree to all statements, terms and conditions above.

Signature of Patient or Legal Guardian: _____

Print Name: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES

Privacy Officer: Razmik Sarkisian
(800) 372-6602

Effective Date: 02/11/2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

A. How This Medical Practice May Use or Disclose Your Health Information

The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. **Treatment**. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or following your death.

2. **Payment**. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires for payment. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. **Health Care Operations**. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve

the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan, healthcare clearinghouse, or one of their business associates, California law prohibits all recipients of healthcare information from further disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their populationbased efforts to improve health or reduce health care costs, protocol development, case management or care coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, their activities related to contracts of health insurance or health benefits, or their health care fraud and abuse detection and compliance efforts. We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.

4. **Appointment Reminders**. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. **Sign-in Sheet**. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. **Notification and Communication with Family**. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you have instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. **Marketing**. Provided we do not receive any payment for making these communications, we may contact you to encourage you to purchase or use products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans we participate in. We may receive

financial compensation to talk with you face-to-face, to provide you with small promotional gifts, or to cover our cost of reminding you to take and refill your medication or otherwise communicate about a drug or biologic that is currently prescribed for you, but only if you either: (1) have a chronic and seriously debilitating or life-threatening condition and the communication is made to educate or advise you about treatment options and otherwise maintain adherence to a prescribed course of treatment, or (2) you are a current health plan enrollee and the communication is limited to the availability of more cost-effective pharmaceuticals. If we make these communications while you have a chronic and seriously debilitating or life-threatening condition, we will provide notice of the following in at least 14-point type: (1) the fact and source of the remuneration; and (2) your right to opt-out of future remunerated communications by calling the communicator's toll-free number. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any financial compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. **Sale of Health Information**. We will not sell your health information.

9. **Required by Law**. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

10. **Public Health**. We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

11. **Health Oversight Activities**. We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.

12. **Judicial and Administrative Proceedings**. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

13. **Law Enforcement**. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

14. **Coroners**. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

15. **Organ or Tissue Donation**. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

16. **Public Safety**. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

17. **Proof of Immunization**. We will disclose proof of immunization to a school where the law requires the school to have such information prior to admitting a student if you have agree to the disclosure on behalf of yourself or your dependent.

18. **Specialized Government Functions**. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

19. **Workers' Compensation**. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

20. **Change of Ownership**. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

21. **Breach Notification**. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current email address, we may use email to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.

22. **Psychotherapy Notes**. We will not use or disclose your psychotherapy notes without your prior written authorization except for the following: (1) your treatment, (2) for training our staff, students and other trainees, (3) to defend ourselves if you sue us or bring some other legal proceeding, (4) if the law requires us to disclose the information to you or the Secretary of HHS or for some other reason, (5) in response to health oversight activities concerning your psychotherapist, (6) to avert a serious threat to health or safety, or (7) to the coroner or medical examiner after you die. To the extent you revoke an authorization to use or disclose your psychotherapy notes, we will stop using or disclosing these notes.

23. **Research**. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. **Right to Request Special Privacy Protections**. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning healthcare items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. **Right to Request Confidential Communications**. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular email account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. **Right to Inspect and Copy**. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary, as allowed by federal and California law. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. **Right to Amend or Supplement**. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that

decision, and we may, in turn, prepare a written rebuttal. You also have the right to request that we add to your record a statement of up to 250 words concerning anything in the record you believe to be incomplete or incorrect. All information related to any request to amend or supplement will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. **Right to an Accounting of Disclosures**. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by email.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend our privacy practices and the terms of this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy will apply to all protected health information that we maintain, regardless of when it was created or received. We will post the current notice on our website at www.NaviMD.com

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Office for Civil Rights, Region IX
U.S. Department of Health & Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
(800) 368-1019; (800) 537-7697 (TDD)

The complaint form may be found at www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf. You will not be penalized in any way for filing a complaint.

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HIPAA - Use & Disclosure of Protected Health Information

Patient Authorization & Acknowledgement of Receipt

Authorization for the disclosure of Protected Health Information (PHI) for Treatment, Payment, or Healthcare Operations (164.508 (a)).

I, the undersigned, understand that as part of my health care, **Valencia Center for Women's Health** originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care of treatment. I understand that this information serves as:

- A basis for planning my care and treatment;
- A means of communication among the health professionals who may contribute to my health care;
- A source of information for applying my diagnosis and surgical information to my bill;
- A means by which a third-party payer can verify that services billed were actually provided;
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of health care professionals.

I have been provided with a copy of the Notice of Privacy Practices that provides a more complete description of information uses and disclosures.

Patient Consent for Use & Disclosure of PHI

Consent to the use and disclosure of Protected Health Information (PHI) for Treatment, Payment, or Healthcare Operations (TPO) (164.506 (a))

I understand that:

- I have the right to review the provider's Notice of Privacy Practices prior to signing this consent;
- The provider reserves the right to revise its Notice of Privacy Practices at any time and that prior to implementation will mail a copy of any revised notice to the address I have provided, if requested;
- I have the right to object to the use of my health information for directory purposes;
- I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or health care operations and that the provider has already taken action in reliance thereon.

By signing below, I hereby give my consent to use and disclose my protected health information (PHI) to carry out treatment, payment and health care operations (TPO).

We may also use any of the following methods to send you appointment reminders, patient statements, surveys, occasional news, educational messages, and information related to insurance issues or your clinical care, including laboratory test results, etc:

- ❑ Mail - to home or other alternate location
- ❑ Telephone - cell phone, home or alternate number. (We may also leave a message on your voicemail)
- ❑ Text Messages (standard text messaging rates may apply)
- ❑ Emails

Signature: _____ **Date:** _____
Print Name: _____ **Telephone:** _____

Complete below if not signed by the patient (please indicate relationship)

Name: _____ Relationship: _____
Address: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communication barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (please specify): _____