2021 HIPAA PATIENT PRIVACY FORM

THIS IS TO NOTIFY **PRINCETON SPORTS & FAMILY MEDICNE, PC** THAT I AM RESTRICTING THE RELEASE OF MY PROTECTED HEALTH INFORMATION. **NO** INFORMATION MAY BE RELEASED WITHOUT MY EXPRESS WRITTEN CONSENT AS INDICATED BELOW.

I HEREBY GIVE PERMISSION TO **PRINCETON SPORTS & FAMILY MEDICINE, PC** TO DISCUSS ANY MEDICAL MATTERS WITH THE FOLLOWING PERSON(S):

NAME **RELATIONSHIP**

_____

_____

_____

I authorize Princeton Sports & Family Medicine, PC to contact me in the following manner:

☐ Home Phone (____) _____
☐ Cell Phone (____) _____
☐ Work Phone (____) _____

☐ OK to mail my home address
☐ OK to leave a detailed voicemail
☐ Leave VM with callback number only

BY SIGNING THIS FORM, I ACKNOWLEDGE AND UNDERSTAND THAT I CAN REVOKE THIS PERMISSION AT ANY TIME BY SUBMITTING A SIGNED STATEMENT, AND THAT PERMISSION WILL REMAIN IN EFFECT UNLESS WE RECEIVE A REVOCATION IN WRITING.

PATIENT NAME: _____ DOB: _____

PATIENT/GUARDIAN SIGNATURE: _____

DATE: _____

PLEASE *FLIP OVER* TO REVIEW OFFICE POLICIES!

PATIENT AUTHORIZATION

☐ I grant consent to all Healthcare Providers of **Princeton Sports and Family Medicine, PC.** to evaluate and treat.

☐ I consent to release to my insurance company any information required, including the diagnosis and records in the course of my exam and treatment.

☐ I understand that outside Healthcare and Educational Institutes may be participating in my treatment and care.

☐ **CANCELLATION | NO SHOW POLICY:** We understand that there are times when you must miss your scheduled appointment due to emergencies or obligations for work or family. However, when you do not call to cancel your appointment, you may be preventing another patient from getting much needed treatment.

We require **at least 24 hours advance notice** to cancel or reschedule your appointment. **If your appointment is NOT CANCELLED at least 24 hours in advance, you will be charged a fee of $50.00.** This fee will NOT be covered by your insurance company.

☐ **INCOMING REFERRAL POLICY:** If your insurance requires a referral to see one of our specialist physicians, and we **DO NOT** have the referral, you will **NOT** be seen.

☐ **OUTGOING REFERRAL POLICY:** If your insurance requires a referral for specialist, labs, or images, we require a **72-hour notice** to submit your referral.

☐ **RETURNED CHECK POLICY:** If your check is returned by your financial institution, you will be responsible for a **$40** return check fee.

PATIENT NAME: _____

PATIENT/GUARDIAN SIGNATURE: _____

DATE: _____