

**TURNER CARE, LLC - PATIENT REGISTRATION**

|  |  |  |  |
| --- | --- | --- | --- |
| Patient Name: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Social Security Number: \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_ |
| Date of Birth: | \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ | Sex: M / F | \_\_\_Married \_\_\_Single \_\_\_Divorced \_\_\_Widow |
| Ethnicity: \_\_Hispanic or Latino \_\_Non Hispanic or Latino \_\_Other \_\_Decline to Specify  Race: \_\_American Indian \_\_Asian \_\_Black \_\_White \_\_Native Hawaiian \_\_Other \_\_Decline to Specify  Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
|  | (Street) |  | (City/State/Zip) |

Home Phone: (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_ E-mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone: (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_

Employer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer Phone Number: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Street) (City/State/Zip)

Referring Physician’s Name & Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about our clinic? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Person responsible for bill or parent (Complete only if different from patient)**

Guarantor Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| Relationship to Patient: (please check): ( ) self, ( ) spouse, or ( | ) parent | Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ |
| Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Employer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Employer Phone Number: (\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

Employer Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Street) (City/Street)

**Who to call for an emergency:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: (\_\_) \_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_ Work Phone: (\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE PRESENT INSURANCE CARD(S) & PHOTO ID FOR COPYING**

**PRIMARY INSURANCE INFORMATION**

Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder’s Social Security Number: \_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_

Policy Holder’s Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Sex: M / F

**SECONDARY INSURANCE INFORMATION**

Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder’s Social Security Number: \_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_

Policy Holder’s Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Sex: M / F

* I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Turner Care, LLC.
* I further agree to pay all collections cost, attorney fees, and other collections cost that may be incurred to enforce collection of any amounts outstanding.
* I acknowledge that I am financially responsible for payment whether or not covered by insurance.
* I authorize Turner Care to treat me and use my personal health information for health care purposes

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Billing Policy**

The following sets forth the general policy of Turner Care, LLC. Please review this information and sign where indicated.

* I understand that it is my responsibility to provide the office of Turner Care, LLC with current, accurate billing information at the time of check in and to notify Turner Care, LLC of any changes in this information.
* I understand that it is my responsibility to know my co-pay and to pay it prior to services being rendered. I understand that this is a contractual agreement that I have with my health plan and that the clinic also has a contractual agreement with my health plan to collect co-pays at the time of service, and they are required to report to the carrier any enrollees failing to pay the co-pay.
* I understand that I will be required to pay with cash, money order, cashier’s check, or credit/debit card.
* I understand that there may be a $30 fee to complete disability paperwork associated with my care. I will be provided a standard form free of charge; however if additional disability forms (such as FMLA) require completion, I understand that the $30 fee (payable prior to completion) is required.
* I understand that I will be billed for any amounts due by me (co-payments/coinsurance amounts/deductibles) and that I have a financial responsibility to pay these amounts. I understand that I will be provided two (2) statements for any balance due after insurance payment. I further understand that if I have not made payment prior to the second statement being mailed, that the second statement will be marked as “Final Notice” and may be sent to an outside collection service if I do not fulfill my financial obligations. I also understand that I will be responsible for any collection, interest or legal expenses associated with the collection efforts.
* I understand that the clinic will obtain the necessary prior authorizations prior to rendering treatment. I further understand that prior authorization is not a guarantee of payment, and that I am responsible for any bills not paid by my insurance carrier.

My signature below confirms that I have read these billing policies and my financial obligation as it pertains to the physicians of Turner Care, LLC.

Patient Legal Signature Date

Responsible Party (If required)

**Current Medical Problems Date of Onset**

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**Past Medical Problems/Hospitalization/Surgeries Dates**

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**Family Medical History: Please list all relatives diagnosed with any of the following conditions including their age at onset (please note if deceased)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Condition** | **Name** | **Age** | **Living or Deceased** |
| *Heart Disease* |  |  |  |
| *Diabetes* |  |  |  |
| *High Cholesterol* |  |  |  |
| *Hypertension* |  |  |  |
| *Colon Cancer* |  |  |  |
| *Breast Cancer* |  |  |  |
| *Ovarian cancer* |  |  |  |
| *Thyroid* |  |  |  |
| *Other* |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Screenings** | **Date of Last** | **Immunizations** | **Date Received** |
| *Mammogram* |  | *Tetanus* |  |
| *Pap Smear* |  | *MMR* |  |
| *Colonoscopy* |  | *Hepatitis B* |  |
| *Bone Density* |  | *Pneumovax* |  |
| *PSA* |  | *PPD (TB Skin Test)* |  |
| *Flu* |  | *Other* |  |

**Screenings & Immunizations**

**Other Specialist that you see on a regular basis**

|  |  |
| --- | --- |
| **Name of Specialist** | **Specialty** |
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I DO ATTEST THAT THE INFORMATION PROVIDED IS TRUE AND CORRECT. I ALSO UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE FOR SERVICES RENDERED TO ME.

Signature Date

**Medication Allergies/Side Effect**

|  |  |
| --- | --- |
| **Name** | **Allergy/Side Effect/Reaction** |
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|  |  |
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|  |  |

Do you have any other allergies? (i.e. food, dyes, environment, insects)

**Medications – Prescription & Non-Prescription**

|  |  |  |
| --- | --- | --- |
| **Name of Medication** | **Strength** | **How Often Taken** |
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**PRIVACY NOTICE, ACKOWLEDGEMENT & CONSENT**

I understand that under the Health Insurance Portability and Accountability Act of 1996 (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 care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
* Obtain payment from designated third-party payers.
* Conduct normal health care operations such as quality assessments or evaluations and physician certifications.

I have been informed and received documentation by Turner Care, LLC of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information (available in the office in print form). I have reviewed such Notice of Privacy Practices prior to signing this consent, and acknowledge that I have read the Privacy Practices. I understand that this organization has the right to change its Notice of Privacy Practices from time to time, and that I may contact this organization at any time at to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Record Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS# \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_

Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Party Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AUTHORIZATION FOR RELEASE, USE & DISCLOSURE MEDICAL INFORMATION**

I authorize the release of my medical records by and to the organization or physician listed below:

Turner Care, LLC

ATTN: Dr. Justin Turner

5240 Robinson Rd Ext.

Jackson, MS 39204

Phone: 601.398.2335

Fax: 601.398.2741

These records are to be sent to Turner Care, LLC at the address above.

Patient’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SS # \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The type and amount of information to be disclosed is initialed as follow: (specify dates where appropriate)

\_\_\_\_ Entire Medical Record \_\_\_\_ Substance and Drug Abuse, if any

\_\_\_\_Immunizations \_\_\_\_ AIDS/HIV, if any

\_\_\_\_History & Physical \_\_\_\_ Genetic testing, from date

\_\_\_\_ X-Ray and Imaging Reports \_\_\_\_Progress Notes

\_\_\_\_Discharge Summary \_\_\_\_ Laboratory Test Results

\_\_\_\_Operative Reports \_\_\_\_Psychological or psychiatric conditions, if any

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Behavioral Health Reports

\_\_\_\_ Social History \_\_\_\_ Treatment Plan

\_\_\_\_Client Data Form \_\_\_\_ Academic History

\_\_\_\_Referral Treatment Form \_\_\_\_ After Care Instructions

\_\_\_\_Admissions Evaluation \_\_\_\_Psychological Evaluation

\_\_\_\_Notification of Admissions

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment of alcohol abuse.

**This information is being provided to you from records whose confidentiality may be protected by State and/or Federal law.**

1. I understand that your facility may receive compensation for medical copying in accordance with State law.
2. I understand that I have the right to inspect and obtain a copy of my protected health information in the designated record sets you or your business associates maintain. I understand however I am not entitled to inspect or obtain a copy of any psychotherapy notes or any information compiled in anticipation of use of or for any civil, criminal or administrative action or preceding any information not subject to disclosure under the Clinical Laboratory Improvements Amendments of 1988, (42 U.S.C. section 263 (a), and certain other records.
3. I understand that I may refuse to sign this authorization and that my refusal to sign may not affect my ability to obtain treatment or payment of my eligibility for benefits. I may inspect or copy any information used or disclosed under this authorization as described above in section #3 above.
4. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by the terms under this authorization.
5. I understand that I may revoke this authorization in writing at any time. To understand that if I revoke this authorization, I must do so in writing and present my writing revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization expires within 90 days unless otherwise specified.

Patient Name (Print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s (or Representative) Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Representative (Print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES**

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.

**WHO WILL FOLLOW THIS NOTICE**

This notice describes the information privacy practices followed by our employees, staff and other personnel.

**YOUR HEALTH INFORMATION**

This notice applies to the information and records we have about you, your health, health status, and the health care and services you receive from Turner Care, LLC. Your health information may include information created and received by Turner Care, LLC, may be in the form of written or electronic records or spoken words, and may include information about your health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, related billing activity and similar types of health-related information. We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

**HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU**

We may use and disclose health information for the following purposes:

• **For Treatment**. We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, staff or other personnel who are involved in taking care of you and your health. For example, your doctor may be treating you for a heart condition and may need to know if you have other health

problems that could complicate your treatment. The doctor may use your medical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you. Different personnel in our organization may share

information about you and disclose information to people who do not work for Turner Care, LLC in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering x-rays. Family members and other health care providers may be part of your medical care outside this office and may require information about you that we have. We will request your permission before sharing health information with your family or friends unless you are unable to give permission to such disclosures due to your health condition.

• **For Payment**. We may use and disclose health information about you so that the treatment and services you receive at Turner Care, LLC may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We

may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will pay for the treatment.

**• For Health Care Operations**. We may use and disclose health information about you in order to run Turner Care, LLC and make sure that you and our other patients receive quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we

should offer, how we can become more efficient, or whether certain new treatments are effective. We may also disclose your health information to health plans that provide you insurance coverage and other health care providers that care for you. Our disclosures of your health information to plans and other providers may be for the purpose of helping these plans and providers provide or improve care, reduce cost, coordinate and manage health care and services, train staff and comply with the law.

**SPECIAL SITUATIONS**

We may use or disclose health information about you for the following purposes, subject to all applicable legal requirements and limitations:

• **To Avert a Serious Threat to Health or Safety**. We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

• **Required By Law**. We will disclose health information about you when required to do so by federal, state or local law.

**• Research.** We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

• **Organ and Tissue Donation**. If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

• **Workers’ Compensation**. We may release health information about you for workers’ compensation or similar programs. These programs provide benefits for work-related injuries or illness.

• **Public Health Risks.** We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

• **Health Oversight Activities.** We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

• **Lawsuits and Disputes**. If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

• **Law Enforcement.** We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

• **Coroners, Medical Examiners and Funeral Directors.** We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

• **Information Not Personally Identifiable.** We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

• **Family and Friends**. We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection.



DECLARATION OF RESPONSIBILTY

I understand and accept responsibility for any charges that are not paid and deemed patient responsibility by the insurance company. These charges include but are not limited to:

* Co-Insurance
* Deductibles
* Co-Pays
* Non Covered Charges that are the Patient’s Responsibility
* Out-of-Network Charges

Signature Date