

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Hancock Physician Network may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Hancock Physician Network's Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices, which may be obtained upon request.

With my consent, Hancock Physician Network may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Hancock Physician Network may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal on Confidential.

I have the right to request that Hancock Physician Network restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Hancock Physician Network's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Hancock Physician Network may decline to provide treatment to me.

Patient's Name

Date of Birth

Signature of Patient or Legal Guardian

Date

Print Name of Legal Guardian (if not patient)

I hereby authorize this office to release any information acquired to establish a health insurance claim.

I hereby authorize this office to release information regarding treatment of drug or alcohol abuse, psychological conditions, HIV testing or an AIDS related condition to establish a health insurance claim.

I hereby authorize Hancock Physician Network to apply for benefits on my behalf for services rendered by him/her, or his/her order. I request that payment from my insurance company or Medicare and Medigap be made directly to Hancock Physician Network (or the party who accepts assignment). I understand that I am responsible for all unpaid charges.

I understand that all charges are to be paid at the time of service unless I present a valid insurance card that represents an insurance carrier with which Hancock Physician Network has contractual agreement. All deductibles co-pays, and non-covered services are expected to be paid at the time of service. If my account is turned over to an outside collection agency, I will be responsible for my balance plus any legal fee(s) or collection fee(s) involved.

In the case of children whose responsible party is someone other than the custodial parent, we must ask that the person accompanying the child to the office make payment at the time of service. Although we empathize with the problems of divorcing parents, we cannot become involved in the financial arrangements of the divorce decree.

Signature (Patient/Parent/Guardian) _____ Date _____

It is your responsibility to notify your insurance company of any impending hospital or surgical admission.

INSURANCE DATA

1. We need to copy your ID card.
2. Does your insurance require precertification? _____ Yes _____ No
3. Does your insurance require a second surgical opinion? _____ Yes _____ No

Name of Laboratory insurance is contracted with _____

All Labs will be sent to Hancock Regional Hospital (HRH) unless we are otherwise informed.
Hancock Physician Network is not responsible for charges resulting from labs being sent to an incorrect lab.

Patient's Initials: _____

Unless otherwise indicated below, we are prohibited from discussing financial or medical issues with anyone but the patient.

Please list anyone that we are authorized to discuss your MEDICAL RECORDS with:

_____ Date: _____

Please list anyone that we are authorized to discuss your FINANCIAL RECORDS with:

_____ Date: _____