Financial Policy for Care Choice, LLC

IT IS CRUTICAL YOU UNDERSTAND THE FINANCIAL POLICY, SO PLEASE READ ALL INFORMATION AND ACKNOWLEGE BY SIGNING BELOW.

1. **We ask that you present your insurance card at your initial visit each year and if you have any changes in insurance. It's your responsibility to provide us with the correct information to bill your insurance.**
2. If you have any change to your: address, telephone number, pharmacy, or employer, please notify the receptionist.
3. **We will collect your deductible, co-payment or charge for non-covered service at the time of your visit. If you have a balance after an insurance payment from a previous service, we will also ask for that payment.**
    - **Our office uses Square which accepts Visa, MasterCard, American Express, Apple Pay, Google pay and Discover. We also accept forms of payment in cash or check that's made out to Care Choice**
4. If we do not participate with your insurance company, you have the option of being a cash patient or change you insurance plan if you can.
5. If your insurance denies our changes or does not pay us in a timely manner, or if your account become delinquent, we reserve the right to refer your account to a collection agency and will be reported to the credit bureau.
6. **HMO Patients**: Your co-payment will be collected at the time of service- Your Primary Care needs to be Magdalena Oleksy, N.P. (NPI- 1205139755)
7. Cash Patients with no insurance will be expected to pay at the time of service.
8. ***Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. It is very important that you understand the provisions of your policy. We cannot guarantee payment of all claims. If your insurance company pays only a portion of the bill or rejects your claim by your insurance does not relieve you of your financial obligation. Remember, whether you do or do not have insurance. You are ultimately financially responsible for payment of your charges.***

I authorize the medical staff and personnel to release my medical information to the insurance company for the purpose of determining and receiving benefits for medical bills. I hereby assign my insurance benefits to be paid directly to Care Choice, LLC.

I have read and have a full understanding of the financial policy of Care Choice, LLC.

Signature:____ Date:____________________

NOTICE AND ACKNOWLEDGEMENT OF PRIVACY PRACTICES OF
Care Choice, PLLC

Effective May 1, 2013

1. We are required by the Federal Government under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to protect the privacy of health information about you and that can be identified with you, which we call "protected health information" or PHI. We must give you notice of our legal duties and privacy practices concerning PHI:
   - We must protect PHI that we have created or received about you past, or future health condition, health care we provide to you, or payment for your health care.
   - We must notify you about how we protect PHI about you.
   - We must explain how, when and why we use and/or disclose PHI about you.
   - We may only use and/or disclose PHI as we have described in this notice.

2. We may use and disclose PHI about you in the following circumstances:
   - We may use and disclose PHI about you to provide healthcare treatment to you.
   - We many use and disclose PHI about you to obtain payment for services.
   - We many use and disclose your PHI for health care operations.
   - We many use and disclose PHI under other circumstances without your additional authorization.
   - We may contact you to provide appointment reminders.
   - We may contact you with information about treatment, services, products, or health care providers.

3. You have several rights regarding PHI about you:
   - You have the right to request restrictions on uses and disclosures of PHI about you.
   - You can object to certain uses and disclosures.
   - You have the right to request different ways to communicate with you.
   - You have the right to see and copy PHI about you.
   - You have the right to request amendment of PHI about you.
   - You have the right to a listing of disclosures we have made.
   - You have a right to a copy of this notice and a right to review the complete Privacy Notice for our practice upon request.

I acknowledge that I have read the above summary of NOTICE OF PRIVACY PRACTICES and been advised that I may review the complete NOTICE OF PRIVACY PRACTICES upon request.

Signature_______________________________________ Date_____________________________

Print Name _____________________________________

CARE CHOICE, LLC

HIPPA RELEASE FORM

Patient Name: ______________________________ DOB:_______________

Privacy regulations require us to have a release signed by our patients so we may speak with family members, friends and other relations regarding your medical treatment and patient financial information. Each person you wish to be considered a contact must be listed individually by name (including a Spouse, family, friend or Significant Other).

Please print name, relationship, and telephone number for each person to whom you are authorizing release of your private health care information and account balances.

______________________________ _______________ ____________________
Name Relation Phone #

______________________________ _______________ ____________________
Name Relation Phone #

______________________________ _______________ ____________________
Name Relation Phone #

______________________________ _______________ ____________________
Name Relation Phone #

If at any time you wish to update this authorization, please inform the office.

____ ____________________

Patient Signature Date