AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Patient Name_______________________________________ DOB_______________________________

Our Notice of Privacy Practices is included in the registration packet for you to read. If you would like a paper copy for your records, please let the receptionist know upon return of your signed paperwork.

I, _____________________________________ *(Print Name)* hereby acknowledge that I have been offered a copy of the Privacy Practices.

Please sign ONLY ONE section below:

1

If a family member or friend calls or comes into the office on your behalf requesting information regarding your medical record (i.e.: samples, labs, appointments, prescriptions, letters, etc.), you authorize CTMG to release or discuss your information with:

Name__________________________ Relationship_________________ Phone____________

Name__________________________ Relationship_________________ Phone____________

Signature____ Date______________________

If not signed by the patient, please indicate relationship:

- ❑ Parent or Guardian of minor patient
- ❑ Beneficiary or representative of deceased patient
- ❑ Guardian/Conservator of an incompetent patient
- ❑ Other (Please specify)____________________________

2

I **DO NOT** wish my medical record to be released or discussed with anyone other than myself. I understand that this does not apply to information needed to process any and all claims by my insurance, or the sharing of information between providers, or their staff for the continuance of my Medical care.

Signature____ Date______________________

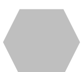
In accordance with applicable federal and state laws, the undersigned acknowledges that this medical group may electronically exchange and/or furnish information which is part of the patient's healthcare and/or medical record to any authorized individual or for the purpose of providing continuum of care, determining liability for payment and other healthcare operations as outlined in the medical groups privacy notice.

Signature____ Date_____________________________

OFFICE USE ONLY - Acknowledgement refused
Reason for refusal____________________________ Employee Signature ____________________________

NOTICE OF PRIVACY PRACTICES
Your Information.
Your Rights.
Our Responsibilities.

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*.**



Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

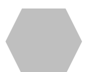
- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
- We will say "yes" unless a law requires us to share that information.



Your Rights *continued*

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violate

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory
- Contact you for fundraising efforts

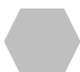
If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.



Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

- We can share health information about you for certain situations such as:
  - Preventing disease
  - Helping with product recalls
  - Reporting adverse reactions to medications
  - Reporting suspected abuse, neglect, or domestic violence
  - Preventing or reducing a serious threat to anyone's health or safety

Do research

- We can use or share your information for health research.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

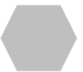
Respond to organ and tissue donation requests

- We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.



Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
  - We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
  - We must follow the duties and privacy practices described in this notice and give you a copy of it.
  - We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This Notice of Privacy Practices applies to all outpatient physician offices and urgent care/retail clinics operated by Carson Tahoe Health, including the following organizations:

Do you have questions?
If you have any questions about this notice, or have further questions about how we may use and disclose information about you, please contact:

Carson Tahoe Health Privacy Officer
PO Box 2168
Carson City, NV 89702
(775) 445-8776
privacyofficer@carsontahoe.org

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Signature as Received

Carson Tahoe Medical Group has a strong tradition of excellence in patient care. We are committed to providing patient and family centered care along with patient's participation. These expectations outline our partnership agreement which is intended to provide compassionate care in an environment that promotes comfort, healing and mutual respect between the patient and Care Team.

Expectation of the Patient and Care Team Partnership Agreement:

- ❖ Patient and Care Team (doctors, advanced clinicians, nurses, medical assistants, technicians, receptionists, schedulers, etc.) will work together to provide the best possible care for the patient in a respectful environment.
- ❖ Any rude, threatening, demeaning comments or behaviors will not be tolerated and will be called out by the Care Team. Such behaviors may result in the patient being discharged from the practice by their Provider. Care Team will ask Security personnel to intervene if negative behaviors continue.
- ❖ Any physically threatening behavior demonstrated by the patient will result in immediate termination of care by the Care Team.
- ❖ Care will be given at previously scheduled times. If patient is not cooperative with agreement, care will be deferred until the next scheduled time.
- ❖ Families are welcomed and recognized as an important part of a patient's healthcare. However, Carson Tahoe Medical Group will not tolerate profanity, disruptive behavior, or any behavior that interferes with the care of any patient.
- ❖ Carson Tahoe Medical Group has Zero Tolerance for any alcohol, smoking or drug use on the clinic property. There is also Zero Tolerance for abusive actions, language or any other behavior that creates risk or a threat to patients, families, visitors or Care Team. Anyone, including family members violating our Zero Tolerance policy will be asked to leave the facility.
- ❖ We appreciate your cooperation with this policy for your safety and the safety of others.

Limits of Confidentiality: The law attempts to protect the privacy of all communications between a patient and health care providers. In most situations the hospital can only release information about a patient to others if the patient signs a written authorization form that meets certain legal requirements imposed by Nevada law and/or HIPAA. However, disclosure will occur at the discretion of Carson Tahoe Health System to those that need to know, including but not limited to the authorities, if the patient commits a crime, threatens or creates risk to patients, families, visitors or the Health Care Team.

______________________________ ___________________________

Patient Signature **Date**

______________________________ ___________________________

Care Team Member **Date**

CARSON TAHOE
HEALTH
Medical Group

FINANCIAL POLICY

It is the policy of Carson Tahoe Medical Group to have a financial policy that clearly outlines patient and practice financial responsibilities. We are committed to providing our patients with quality medical care and also minimizing administrative costs. The financial policy has been established with these objectives in mind and to avoid misunderstandings or disagreements concerning payment for professional services.

*****At each visit please be prepared to show your photo ID and Insurance Card*****

Patient Responsibility

- **It is the patient's responsibility to know what their insurance does and does not cover.** In addition, it is your responsibility to verify whether the facility is contracted with your plan. You can find out more about your insurance by calling the phone number on your card or through your human resources department.
- It is the patient's responsibility to pay any deductible, co-payment or any portion of the charges as specified by the plan. Payments for medical services not covered by an individual's insurance plan are the patient's responsibility. The exact amount of payment is a contract between you and your insurance carrier. Our contracts with your insurance carrier require us to collect these monies and bill for the services we render to you.
- It is the patient's responsibility to insure that any required referrals or prior authorizations for treatment are provided to the practice a minimum of 24 hours prior to the visit. If there is a need to reschedule with less than 24 hour notice, due to the lack of referral information the patient may be financially responsible for a $50.00 fee.
- If an appointment is cancelled with less than 24 hours' notice, the patient may be billed a $50.00 fee.
- Any no show, no call visit may be billed a $50.00 fee. Multiple no shows will be dismissed from the practice.

Payment

- CTMG will collect any co-payment or deductible at the time of service at the registration desk before your visit. We accept cash, checks, debit cards and credit cards (MasterCard, Visa and Discover).
- The adult accompanying a minor is responsible for payment at the time of service.
- Returned checks will be charged a non-sufficient funds charge of $50.00.
- Patients with outstanding account balances and without payment arrangements, may be rescheduled for not emergent appointments.

FINANCIAL POLICY (Cont.)

Self Pay

- If you do not have insurance, your payment is due, in full, at the time of the visit. We do provide a discount to Self Pay patients who pay, in full, at the time of the visit. This discount is forfeited otherwise. We will work with you to settle your account. Please ask to speak with our staff if you need assistance.

Insurance Billing

- As a courtesy, we will bill your insurance; however, please note in order to bill insurance, we require all the necessary information (i.e. Insurance card) on the insured at the time of service, and updated every year.
- If we bill your insurance, once we receive the insurance payment, we will send you a statement for the remaining patient balance if applicable. This balance will be due upon receipt. Please plan accordingly to settle your balance or contact us to discuss arrangements.

Out of area and non-contracted insurance plans

- **We expect payment at the time of service unless other arrangements have been made.** We will provide you with an itemized bill that you may submit to your insurance carrier for direct reimbursement.

Payment Plans

- Payments are due for services rendered on the date of service. If you have financial difficulties, we can set up a Patient Payment Agreement with a minimum monthly payment of $50.00.
- We have information on local, low cost Medical Care Facilities to help you with your health care needs.

Our practice firmly believes that a good physician-patient relationship is based upon understanding and good communication. Questions about financial arrangements should be directed to the Practice Manager. We are here to help you. By signing you are stating that you have reviewed and understand this Financial Policy.

Signature____ Date______________________________

If patient is a Minor – Parent/Guardian Signature

ePrescribing Consent

ePrescribe is defined by a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) 2003, listed standards that have to be included in an ePrescribe program.

These include:

- **Formulary and benefit transactions**
  These give the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions**
  These provide the provider with information about medications the patient is already taking to minimize the number of adverse drug events.

By signing this consent form, you are agreeing that Carson Tahoe Medical Group can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

Understanding all of the above, **I hereby provide informed consent** to Carson Tahoe Medical Group to enroll me in the ePrescribe program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

❑ **YES** - By signing below, I hereby **CONSENT**

Patient Name____ DOB__________________________________

Signature____ Date_________________________________

❑ **NO** - By signing below, I hereby **DENY** consent

Patient Name____ DOB__________________________________

Signature____ Date_________________________________

Send completed form to Welcome@carsontahoe.org