HEALTHFIT – HIPPA Privacy Policy, Treatment Consent, Claims Processing Consent

We want you to know how your Patient Health Information (PHI) is being used and your rights regarding your health information. Should we change our notice, you may obtain a copy of the revised notice by telephoning our office.

Before we provide any health care service, we require that you read and accept the provisions contained herein. If you require a more detailed account of our policies regarding your PHI privacy, we encourage you to read the HIPPA NOTICE that is available in our reception room. By signing this agreement you acknowledge and agree to the following terms and provisions:

1. You agree to allow our office to use your PHI for the purpose of treatment, payment, health care operations and coordination of care. An example would be using your PHI to submit necessary claims for reimbursement from insurance carriers with whom you have contracted.
2. You have the right to examine and obtain copies of your health records at any time and you have the right to request corrections be made if in error. By written request you have the right to restrict the use of your PHI.
3. Your written request is required only once for initial and all subsequent care rendered by this facility. You may revoke this consent at any time during or after your care. Such revocation will not apply to any care rendered prior to the actual date of revocation.
4. To protect your security and your right to privacy, our staff has been trained in patient record privacy and a privacy officer has been designated to enforce our policy. Personal financial information is kept separate from your health file and accessible only to select First Health personnel.
5. You have the right to file a complaint with our privacy officer if you have been personally affected or if you have concerns about the privacy of your information.
6. By refusing to sign this agreement, we have the right to refuse care.

Consent for Treatment

HEALTHFIT offers both conventional medical and various forms of alternative care. Alternative care is not a substitute for conventional medical care and we recommend that if you partake in any form of alternative therapy that you be under the simultaneous care of your own personal physicians. As with any form of health care we make no guarantees of success and you are free to discontinue care at any time.

Medicare and Medicaid Consent to Release Information

I certify that the information given by me in applying for payment under Title XVIII and/or Title XI of the Social Security Act is correct. I authorize any holder of medical information concerning my health to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid Claim(s).

Verification of Non-Pregnancy (Females Only)

I certify that to the best of my knowledge; I am not pregnant nor is pregnancy suspected or confirmed at this particular time.

Health Insurance Submission and Claim Authorization

I give HEALTHFIT the authorization to submit insurance claims for any and all treatment provided now and in the future. In lieu of payment at the time of service I hereby assign to HEALTHFIT the right to collect fees for services owed by me directly from my insurance carrier. I will assist HEALTHFIT in such collection process. Since time is of the essence I will provide HEALTHFIT or my insurance carrier any additional information needed to process my claim within 24 hours from written or documented verbal requests by either.

I have read, understand and accept the above policies and procedures. By signing below, I give consent for treatment, authorize insurance carrier benefit assignment and understand HEALTHFIT HIPPA privacy policies.

Patient Name (Please Print) _____

Last First Middle

Patient (Guardian) Signature _____ Date _____

Front Desk Witness _____ Date _____