Authorization to Contact Patient and Record of Disclosures

The Health Insurance Portability and Accountability Act (HIPAA) gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

___email.

___Okay to leave a message with detailed information.

___Leave a message with call back number only.

___Work/Home Telephone.

___Okay to text my cell phone.

___Written communication.

___Okay to mail to my home address.

___Okay to mail to my work/office address.

___Okay to fax to: _____.

___Other _____.

Office Use Only

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Healthcare entities must keep records of PHI disclosures. The information provided below, if completed properly, will constitute an adequate record.

NOTE: Uses and disclosure for TPO may be permitted without prior consent in an emergency.

Date_____ Disclosed to whom_____
Description of disclosure_____
By whom Disclosed_____ Address or fax number_____
Purpose of Disclosure_____

___1. Check box if disclosure is authorized.
___2. Enter how disclosure was made: F-fax, E-e-mail, M-mail, O-other

Comments: _____

_____

_____

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. If you have any questions about this Notice please contact: the office manager. This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information, ("P.H.I."), to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your right to access and control your "P.H.I.". "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all "P.H.I." That we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices if you call the office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment.

Uses and Disclosures of "P.H.I." Based upon Your Written Consent

You will be asked by your Provider to sign a consent form. Once you have consented to use and disclosure of your "P.H.I." for treatment, payment and health care operations by signing the consent form, your Provider will use or disclose your "P.H.I." as described in this Section 1. Your "P.H.I." may be used and disclosed by your Provider, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Following are examples of the types of uses and disclosures of your "P.H.I." that a Provider's office is permitted to make once you have signed our consent form. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided consent.

Treatment: We will use and disclose your "P.H.I." to provide, coordinate, or manage your health care and any related services. This could include the coordination or management of your health care with a third party that has already obtained your permission to have access to your "P.H.I.". For example, we would disclose your "P.H.I.", as necessary, to a home health agency that provides care to you. We will also disclose "P.H.I." to other Providers who may be treating you when we have the necessary permission from you to disclose your "P.H.I.". For example, your "P.H.I." may be provided to a Provider to whom you have been referred to ensure that the Provider has the necessary information to diagnose or treat you. In addition, we may disclose your "P.H.I." from time-to-time to another health care provider (e.g., a specialist or laboratory) who, at the request of your Provider, becomes involved in your care by providing assistance with your health care diagnosis or treatment.

Payment: As your services will be completely paid on the date of service or agreements for credit issuing agencies signed, we do not release any billing information to anyone but yourself and then only with consent from you to do so.

Healthcare Operations: We may use or disclose, as-needed, your "P.H.I." in order to support the business activities of your Provider's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of employees, licensing, marketing, and fundraising activities, and conducting or arranging for other business activities.

For example, we may disclose your "P.H.I." to employees that see patients at our office. We may also call you by name in the waiting room when your Provider is ready to see you. We may use or disclose your "P.H.I.", as necessary, to contact you or remind you of your appointment.

We will share your "P.H.I." with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your "P.H.I.", we will have a written contract that contains terms that will protect the privacy of your "P.H.I.".

We may use or disclose your "P.H.I.", as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your "P.H.I." for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact and request that these fundraising materials not be sent to you. We may use or disclose your demographic information and the dates that you received treatment from your Provider, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Contact and request that these fundraising materials not be sent to you.

Uses and Disclosures of "P.H.I." Based upon Your Written Authorization. Other uses and disclosures of your "P.H.I." will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your Provider or the Provider's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May be made with Your Consent, Authorization or Opportunity to Object. You have the opportunity to agree or object to the use or disclosure of all or part of your "P.H.I.". If you are not present or able to agree or object to the use or disclosure of the "P.H.I.", then your Provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the "P.H.I." that is relevant to your health care will be disclosed.

You have the right to inspect and copy your "P.H.I.". Patients have the right to inspect and receive copies of their medical records. This practice may charge for the copying of the record, as well as supplies, labor, and postage, and the patient should be notified of this cost in advance. The patient should agree to this financial responsibility in writing, in advance. This practice has the right to deny a patient's request to inspect and copy their medical record. This denial must be in writing and explain why the request has been denied.

There are several circumstances when the denial may not be appealed (unreviewable denial): These include but are not limited to: Psychotherapy notes; information compiled in reasonable anticipation of or for use in a civil, criminal, or administrative action proceeding; "PHI" maintained by the practice subject to Clinical Laboratory Improvements Amendments (CLIA) (to the extent access to an individual would be prohibited by law); "PHI" regarding an inmate at a correctional facility; in research situations, if the patient was advised prior to the study; if the information was obtained from someone other than a health care provider and if access would compromise an individual providing information under a promise of confidentiality.

The patient can appeal the denial and has the right to request review by another Provider designated by the practice and who was not a part of the original decision to deny access (reviewable denial). These include but are not limited to: if a Provider determines that the requested access would endanger the life or physical safety of the individual or another person; if the record makes reference to another person and the Provider believes the access could cause substantial harm to that person; request has been made by patient's personal representative and the Provider believes it could cause harm to that individual or another person.

You have the right to request a restriction of your "P.H.I.". This means you may ask us not to use or disclose any part of your "P.H.I." for the purpose of treatment, or payment of healthcare operations. You may also request that any part of your "P.H.I." not be disclosed to family members or friends who may be involved in your care. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your Provider is not required to agree to a restriction that you may request. If your Provider believes it is in your best interest to permit use and disclosure of your "P.H.I.", your "P.H.I." will not be restricted. If your Provider does agree to the requested restriction, we may not use or disclose your "P.H.I." in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your Provider. You may request a restriction in writing.

You have the right to request confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact.

You have the right to receive an accounting of certain disclosures we have made, if any, of your "P.H.I.". This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosure we may have made to you, to a facility director, to family members or friends involved in your care, or for notification purposes. Your right to receive this information is subject to certain exceptions, restrictions, and limitations.

You have the right to obtain a paper copy of this notice from us. Upon request, even if you have agreed to accept this notice electronically.

Complaints. You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Contact (office manager) of your complaint. We will not retaliate against you for filing a complaint. You may contact our office for further information about the complaint process. This notice was published and became effective on January 1, 2000.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices

Name: _____Signature:_____Date:_____

Provider-Patient Arbitration Agreement

Article 1 - **Agreement to Arbitration:** It is understood that any dispute as to medical malpractice, that is, as to whether any medical service rendered will be determined by submission to arbitration as provided by North Carolina law, and not by a lawsuit or resort to court process except as North Carolina law provides for judicial review of arbitration processing. Both parties to this contract by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and are instead accepting the use of arbitration.

Article 2 - **All Claims must be decided by Arbitration:** It is the intention of the parties that this agreement binds all parties whose claims may arise out of or relate to treatment or services provided by the Provider including any spouse or heirs of the patient and any children, whether born or unborn at that time of the occurrence given rise to any claim. In the case of any pregnant mother the term "patient" herein shall mean both the mother and the mothers expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of small claims court against the Provider and Provider's partners, associates, association or partnership and employees, agents and estates of any of them must be arbitrated including without limitations, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any actions in any court by Provider to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against the Provider, any fee dispute shall be resolved by arbitration, whether or not the subject of any existing court action.

Article 3 - **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have absolute right to arbitrate separately the issue of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of North Carolina law applicable to health care providers shall apply to disputes within this arbitration agreement.

Article 4 - **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one processing. A claim shall be waived and forever barred if (1) on the date notice thereof is received the claim, if asserted in a civil action, would be barred by the applicable North Carolina statute of limitation, or (2) the claimant fails to pursue arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for the arbitration shall be governed by the North Carolina Arbitration Statute.

Article 5 - **General Provisions:** This agreement may be revoked by written notice delivered to the Provider within 30 days of signature and if revoked will govern all medical services received by the patient.

Article 6 - **Retroactive Effect:** If patient intents this agreement to cover services rendered before the date it is signed (including, but limited to emergency treatment) patient should initial below:

Effective as of the date of first received medical service.

_____
Patient or Parent or Representative's initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain full forced and shall not be affected by invalidity of any other provision. I understand that I have the right to receive a copy of the arbitration agreement. By my signature below I acknowledge that I have received a copy.

Notice: By signing this contract you are agreeing to have any issue of medical malpractice decided by neutral arbitration and you are giving up your right to a jury or court trial (see Article 1 of contract).

_____ _____
Provider or Authorized Representative's Signature Date

Print Patient's Name Date

_____
Patient's Signature

_____
Signature of Translator (if applicable) Date

_____
Print Name and Relationship to Patient Date

_____
Print Name of Translator

_____
Patient's Representative Signature

A signed copy of this document is available upon request by the patient. The Original is to be filed in the Patient's medical records.