PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

In general, any information that is about your health care you receive, or payment for that care, is considered confidential and protected by our practice. We may use Protected Health Information to carry out treatment, payment, health care operations, and/or other purposes. Our "Notices of Privacy Practices" provides a more complete description of permitted uses and disclosures.

ASSIGNMENT AND RELEASE OF BENEFITS

I hereby authorize payment directly to Family Medical Care for all Insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, co-pays, and deductibles, whether or not paid by Insurance, and for all services rendered on my behalf or my dependents. I authorize the use of this signature on all insurance submissions**.**

PATIENT LIABILITY FOR NON-COVERED/INELIGIBLE SERVICES

I understand that the service I will be provided with via my Healthcare Provider or office staff may or may not be covered by Insurance. I understand that it is my responsibility to know my individual insurance plan's covered services, and that Family Medical Care is not responsible to know whether my Insurance will pay or require prior authorization. If any services I receive at the facility at any time during my course of treatment are deemed non-covered or ineligible or any other reasons unpaid, as well as all efforts are made to obtain payment from my Insurance, I understand I am financially responsible for payment of the denied services**.**

ELECTRONIC RECORD TRANSFER

I understand that Family Medical Care participates in one or more Health Information Exchange. Your healthcare provider can use this electronic network to securely provide access to your health records for a better picture of your health needs. We and other healthcare providers, may allow access to your health information through the Health Information Exchange for treatment, payment or other healthcare operations. This is an automatic op-in program; however you may opt-out at any time by notifying our Compliance Manager.

I further understand that it may be necessary to transmit my medical records/prescriptions electronically and I authorize to do so. I understand that if I need to ***transfe***r my medical records, that I am required to sign a separate ***AUTHORIZATION TO RELEASE*** form with the Medical Records department. I absolve Family Medical Care and its personnel of any liability relating to the transfer of said records.

AUTHORIZATION TO TREAT

I hereby authorize any provider employed as part of Family Medical Care to administer such treatment and perform such procedures as may be deemed necessary or advisable in the diagnosis of this patient which may or may not be myself. I hereby authorize my insurance benefits to be paid directly to Family Medical Care Community Health Center, realizing that I am responsible to pay non-covered services. I hereby authorize the release of pertinent medical information to my insurance plan.

BY SIGNING BELOW, I ACKNOWLEDGE THAT THE INFORMATION I PROVIDED IS ACCURATE TO THE BEST OF MY ABILITY.