Carson Midwifery & APRN Clinic
937 Mica Drive #16B, Carson City, NV 89705
PO Box 99, Minden, NV 89423
Phone: 775-546-2850 **Fax: (775) 546-2868**

Notice of Privacy Practices Acknowledgment (HIPAA Form)

I acknowledge that I have been offered / received a copy of **Carson Midwifery & APRN Clinic (CMAC)** Notice of Privacy Practices and have had an opportunity to review it. I have also been given an opportunity to request restriction on the use and disclosure of my protected health information, as well as to request confidential treatment of communications relating to my health information.

_____

Patient acknowledgement (Signature) Date

Consent for Purposes of Treatment, Payment and Health Care Operations

I understand that, as a condition to my receiving treatment Melinda Hoskins, APRN, CNM, IBCLC may use or disclose my personally identified health information for treatment to obtain payment for the treatment provided and as otherwise necessary for the operations of **Carson Midwifery & APRN Clinic.** These uses and disclosures are more fully explained in the Notice of Privacy Practices that has been provided to and reviewed by me.

While I am here, I permit the midwife, other employees, and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand the attending practitioner will explain to me the nature of my condition, her recommended treatment and any associated risk involved. I also understand that she will explain to me other ways this condition could be treated. I further understand that this care may include diagnostic testing, examinations, and medical and/or surgical treatment, and that no guarantees have been made to me about the outcome of this care.

"Personally identifiable health information" refers to health and demographic information collected about me by my physician (or other health care provider, public health authority, health plan, employer, life insurer, school or university, or health care clearinghouse) that relates to my past, present or future physical or mental health or condition or payment for provision of health care. The information identifies me, or there is a reasonable basis to believe that the information may identify me.

I understand that privacy practices described in the Notice of Privacy Practices may change over time and that I have a right to obtain any revised Privacy Notice by contacting **CMAC** to make such a request. I may receive a revised Notice of Privacy Practices by calling the office and requesting a revised copy by mail or by asking for one at my next visit.

I also understand that I have the right to request **CMAC** to restrict how my health information is used or disclosed. **CMAC** does not have to agree to my request for the restriction, but if **CMAC** does agree, **CMAC** is bound to abide by the restriction as agreed.

Finally, I understand that I have the right to revoke/withdraw this consent, in writing, at any time. My revocation/withdrawal will be effective except to the extent that **CMAC** has taken action in reliance on my consent for use or disclosure of my health information. Provision of future treatment may be withdrawn if I withdraw my consent.

_____

Signature Date

Patient name:_____ Date of birth: _____

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Financial Policy

Thank you for choosing The **Carson Midwifery & APRN Clinic** as your health care provider. We are committed to quality patient care at the lowest possible cost. The following is a statement of our financial policy.

Insurance Plans

If we are participating providers for your insurance plan, all co-pays and deductibles are due at the time of service. We are obligated to submit claims within a specific time frame and to accept the company's determination of fee as final. In turn the company is obligated to provide us with information regarding your deductible and copay at the time of service. This involves time on our part for contacting the company and determining your obligation. To properly bill your insurance company and avoid untimely delays, we require that you provide us with accurate insurance information and allow us to maintain a copy of your insurance card on file.

In the event that your insurance coverage is a plan with which we do not participate, we do not accept assignment of insurance benefits and we do not bill your insurance company. Payment by cash, check, credit or debit card (Discover, AMEX, VISA, MasterCard, HSA Fund cards) is expected at the time of service. We will provide you with information necessary to submit your claim to your insurance company. Your policy is a contract between you and your insurance company.

Self Pay

We are happy to accept self payment at the time of service. If you are self-pay or we do not participate with your insurance plan and thus are not obligated to submit an insurance claim on your behalf, we extend a 10% discount for payment in full at the time of service. We cannot extend this discount to those who have insurance with companies with which we are contracted, even in the event you have a high deductible plan.

Minors

A minor must be accompanied by a guarantor for his or her account (the parent or guardian of the minor or other adult accompanying the minor during each visit). Appropriate consent for treatment of the minor child must be provided by the custodial parent or guardian. Occasionally circumstances will arise in which a minor child may seek treatment without a parent present and specific consent must be provided for such services. Financial arrangements must be made in advance for any unaccompanied minor seeking authorized treatment. An unaccompanied minor will be denied non- emergency treatment unless charges have been pre-authorized to an approved credit plan or insurance plan.

Acknowledgement: I have read and understand the above Financial Policy and Benefit Authorization and agree to all provisions outlined herein.

_____

Signature of patient or responsible party Date

Assignment of insurance benefits:

I, _____hereby request that payment of authorized insurance benefits, for each of the following insurers, whether primary or secondary payers, including Medicare and Medicare supplemental policies, if I am a Medicare beneficiary, be made on my behalf to the above named entities for any medical services provided to me by these healthcare providers.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, the Centers for Medicare and Medicaid (CMS), my insurance carrier or other medical entity. A copy of this authorization will be sent to CMS, my insurance company or other entity if requested. The original will be kept on file by these entities.

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I understand that I am financially responsible to the above named entities for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the entities and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for services received.
A photocopy of this form shall be considered as effective and valid as the original. In addition on electronic claims a statement that "signature on file" shall also serve to authorize this assignment.

I understand that I may revoke this authorization at any time and my revocation shall become effective for any subsequent service claims, while this authorization will remain in effect for any services received prior to the notice of revocation.

_____

Signature: Date:

Primary Insurance carrier: _____ Policy number _____

Insurance plan name: _____ Group No. _____

Effective date: _____ Policy through: Self / Spouse / Parent Other: _____

Name of Insured: _____ DOB:_____

Secondary insurance carrier: _____ Policy number _____

Insurance plan name: _____ Group No. _____

Effective date: _____ Policy through: Self / Spouse / Parent Other: _____

Name of Insured: _____ DOB:_____

[ ] Medicare lifetime consent & Medicaid:I certify that the information given by me in applying under Title XVII of the Social Security Act is correct, and I authorize any holder of medical or other information about me to release it to the Social Security Administration or its intermediaries or carriers as needed for this or a related Medicare claim. I assign the benefits payable for the provider services to the provider or organization furnishing the services or authorize such provider or organization to submit a claim to Medicare for payment to me.

_____

Signature: Date:

Patient name:_____ Date of birth: _____

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Personal Financial Representative Designation

Carson Midwifery & APRN Clinic staff may discuss or release Personal Health Information to the Personal Representative(s) regarding the following information: eligibility, billing, payment status, benefits, claims, medical information used to make payment decisions, providers, appeals, and complaints about my health insurance coverage.

Authorized use and/or disclosure: I authorize clinic staff to release Personal Health Information to the person(s) named as my Personal Representative for the purpose of assisting with, or facilitating, the coordination or payment of my health plan benefits.

I also understand that if my Personal Representative is not a health care provider or other person subject to federal privacy laws, my Personal Health Information may no longer be protected by those privacy laws and may be subject to re-disclosure by my Personal Representative. **Carson Midwifery & APRN Clinic** is not responsible should my Personal Representative further disclose my protected Personal Health Information.

I further understand that I have the right to limit the information that you release under this authorization. Limitations for disclosure are identified below. By leaving this section blank, I am creating a "no limitation" on disclosure of Personal Health Information. ____ initial here if left blank

Disclosure limitations:

_____

_____

Revocation
I understand that I may revoke this authorization at any time by giving written notice to the clinic. Revocation will not affect any action that the clinic has taken or any information that has been released based upon prior authorizations.

Designation of personal representatives(s)

Name of authorized person:	Relationship to patient:	SS#:
Name of authorized person:	Relationship to patient:	SS#:
Name of authorized person:	Relationship to patient:	SS#:

Signature and authorization: I, the undersigned, do hereby swear that I am the above-mentioned patient or an authorized legal representative of the above-mentioned patient. I have read and understand the content of this Personal Representative Form. My signed authorization is voluntary and I acknowledge that the information released may include protected and individually identifiable information about me.

_____

Signature: Date:

Patient name:_____ Date of birth: _____

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Authorization to Share Medical Information with Family Members or Friends

I hereby authorize the APRNs of the Carson Midwifery & APRN Clinic and their staff members to discuss my diagnosis, prognosis and medical care with the following people:

Name: _____ Phone: _____

Relationship: _____

Name: _____ Phone: _____

Relationship: _____

Name: _____ Phone: _____

Relationship: _____

Name: _____ Phone: _____

Relationship: _____

If I wish to revoke this authorization I must do so in writing. I understand that by giving this permission it is possible that someone with whom the healthcare providers discuss my care may make known to other parties information that would ordinarily be considered protected personal health information. I will not be able to hold the healthcare providers responsible for such third party disclosure.

_____

Signature: Date:

Patient name:_____ Date of birth: _____