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HIPAA Consent and Financial Policy

Date _____ Name_____ DOB _____

Desert Holistic Health and its employees are required by law to protect your health information. We have the right to change this notice, and if we do so we will notify you in writing. If we bill your insurance for any visits then we have an obligation to share information with your insurance company and our billing company. We may disclose information to attorneys, accountants, or credit card processors for legal purposes and general healthcare operations. We may also use your information without your consent for the following reasons: Emergency situations when we are unable to obtain your consent, when required by law, product recalls, victim of abuse/neglect/domestic violence, for public health activities (such as required reportable diseases), lawsuits and worker's compensation. You have the right to decide how personal health information (PHI) is communicated, make amendments to your PHI, and obtain copies of your PHI. You have a right to the list of any disclosures we have made. If you feel we have violated your privacy rights you may contact the US Departments of HHS government center. Any disclosure of your personal health information would require your prior written consent; this includes obtaining copies for yourself. PHI copy requests may take up to 10 days to receive. We will not disclose your PHI to any other healthcare provider without your written consent. In some cases it may be necessary for us to collaborate with your healthcare provider prior to initiation of a health program, in that case you will be notified of this and can choose to move forward or not.

Signature _____

Thank you for choosing Desert Holistic Health as your primary care provider. We are committed to providing you with quality and affordable healthcare. We ask all patients to review and sign this policy, asking questions as necessary. A copy will be provided to each patient upon request.

All patients are required to have a credit card on file in the event of a no-show, late cancellation, or a due balance on the account. Insurance: We accept assignment and participate in some insurance plans. If your insurance is not a plan we participate in, payment in full is expected at each visit. Knowing your insurance benefits is your responsibility. Please contact your insurer with any questions you may have regarding your coverage to receive the maximum benefit.

Patient Payment: All copayments and deductibles are to be paid at the time of service. This arrangement is part of your contract with your insurance company.

Forms: There is a $25 fee for completing FMLA, sick leave, AFLAC, and disability insurance forms. This fee must be paid before the forms are completed. There is also a $5 fee for any forms that need to be faxed or mailed.

Registration for Insurance patients: All patients must complete our patients information forms, which will be entered into our computer to maintain accurate information for proper billing. We must obtain a copy of your drivers license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information, or your insurance changes and you fail to notify is in a timely manner, you may be responsible for the balance of a claim. Most insurance companies have time filing restrictions; if a claim is not received within 30 days of the date of service, it can be rendered ineligible for payment and you will be responsible for the balance that remains.

Claims: We will submit your claims for in network insurance and assist you in any way we reasonably can to help get your claims paid. Your insurance company may not accept information from our office and may need information from you. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance company pays or not. Your Out of network insurance: Please see our fee schedule for visit costs. The full balance of the visit will be due at the time of your visit. We will provide you with a superbill to submit to your insurance company. It is your responsibility to submit the claim and understand your out of network benefits.

Uninsured Patients: Please see our fee schedule for visit costs. All patients are required to have a cred card on file. See below or credit and collection details. Any account balance over 90 days will be subject to review for collection action.

Credit and Collection: Invoices will be sent of any bill past due. If an account is more than 30 days past due, the credit card on file will be charged. Partial payments will not be accepted unless otherwise approved prior to service. Please be aware that if a balance has remained unpaid, it may be sent to a collection agency. If an account is sent to collections, it is the policy of this office to discharge the patient. You will at that time be notified by regular and verified mail that you will have 30 days to find alternative medical care.

Phone management fee: There will be a $75 charge for managing and treating a minor acute illness (e.g., cold, flu, or sinus congestion) over the phone. The phone management fee will not be billed to your insurance and is your full responsibility.

Missed appointments: Our policy is to charge $50 for missed appointments not canceled within 23 hours of the scheduled appointment. Rescheduling the appointment does not mean this fee will be waived as we often are not able to book that time slot with such short notice. These charges will be your responsibility and billed to the credit card on file. Please help us serve you better by keeping your regularly scheduled appointment.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read and understand the financial policy and agree to abide by its guidelines

Signature_____