Notice of Privacy Practices Short Form

Our practice is committed to educating our patients about healthcare issues that affect them. As a result, we are providing you with general information about the Privacy Rules, a federal regulation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

What is HIPAA and how does the privacy rule affect you?

When the Health Insurance Portability and Accountability Act (HIPAA) was passed in August of 1996 this gave the federal government the ability to mandate how healthcare plans, providers, and clearinghouses store and send a patient's personal information as it relates to healthcare. The Privacy Rule was created to protect your rights as a patient of our practice and we are required by law to be compliant with this regulation on April 14, 2003. Under the Privacy Rule you are guaranteed access to your medicals records, allowed control over how your protected health information is used and disclosed and allowed to take action if your privacy is compromised by
following the practice's policy. Our practice is dedicated to maintaining the privacy of your personal information.

What is individually identifiable health information (IIHI)?

Any health information you provide, including your mailing address, information that is created and retained by our practice or received by another healthcare provider that relates to treatment, payment and/or that identifies you as an individual.

The following categories best describe the different ways in which we may use and disclose your IIHI:

Treatment, Appointment Reminders, Release of Information to Family/Friends, Payment, Treatment Options, Disclosures Requires by Law Healthcare Operations, Health Related Benefits and Services

The following categories describe unique situations in which we may use or disclose your IIHI:

Public Risks, Health Oversight Activities, Lawsuits, Law Enforcement
Serious Health Threats/Safety, Research

You may request to view our full Notice of Privacy at anytime. The undersigned Patient or legally authorized representative "Agent" of the Patient acknowledges that he or she personally received or was offered a copy of the MidMichigan Neuropsychology Associates Notice of Privacy policies.

INSURANCE AUTHORIZATION RELEASE OF INFORMATION

INSURANCE NAME/ID#/GROUP: _____

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I AUTHORIZE MIDMICHIGAN NEUROPSYCHOLOGY ASSOCIATES, P.L.C. TO RECEIVE INFORMATION AND RELEASE INFORMATION TO THE INSURANCE COMPANY LISTED ABOVE,RENDERED BY MIDMICHIGAN NEUROPSYCHOLOGY ASSOCIATES. THIS AUTHORIZATION SHALL BE IN EFFECT FOR A PERIOD OF ONE YEAR FROM TODAY.

AGREE TO PAY

I hereby authorize MidMichigan Neuropsychology Associates, PLC, neuropsychologists and/or its designees to release to my insurance company and/or third-party payor(s) and/or external review agency(s) such information contained in my patient record as is necessary for the payment of insurance benefits without regard to any limitations placed on dates, history or illness or diagnostic and therapeutic information including any testing and/or treatment for AIDS, AIDS-Related Complex (ARC) or HIV infection (MI 1989 Public Act 174). This authorization expires upon full payment of insurance benefits unless previously revoked, and may be revoked at any time except to the extent that action has been taken by MidMichigan Neuropsychology Associate, PLC in reliance thereon. I certify information furnished for this claim to be true and correct.

ASSIGNMENT: I assign to MidMichigan Neuropsychology Associates, PLC, its neuropsychologists and/or designees all rights to benefits, insurance proceeds, settlement payments or judgements I may be entitled for services rendered.

AGREEMENT: I understand that any amounts not paid by my insurance are my responsibility. Also, I understand that bills not paid within 30 days of services rendered by MidMichigan Neuropsychology Associates, PLC, may be charged 1.5% service charge per month (18% APR) on any unpaid balance.

MEDICARE PATIENTS: I request payment to MidMichigan Neuropsychology Associates, PLC of authorized Medicare benefits for any services furnished by MidMichigan Neuropsychology Associates, PLC, rendered on my behalf. I authorize any holder of medical or other information about me to release to Health Care Financing Administration, its agents and other carriers, any information needed to determine these benefits or benefits for related services. This request is effective until revoked in writing.

PATIENT NAME: _____

SIGNATURE: _____ **DATE:** _____

RELATIONSHIP TO PATIENT: _____

WITNESS: _____ **DATE:** _____

RELATIONSHIP TO PATIENT: MIDMICHIGAN NEUROPSYCHOLOGY STAFF