NOTICES OF PRIVACY PRACTICES

Welcome to the Montgomery Women's Medical Center DBA Montgomery Fertility Center. This document (the Agreement) contains important information about professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that we provide you with a
Notice of Privacy Practices (the Notice) is for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information at the end of your first visit.

What is Health Information?

Whenever Montgomery Fertility Center (MFC) treats you, **health information** is created. Health information may be written (e.g. a medical record), spoken (physicians discussing x-rays), or electronic (bills saved on computer disks).

The Law Permits MFC to Use or Disclose Health Information for the following routine activities: For Treatment; for Payment; for Health Care Operations (risk assessment programs, credentialing and training); for Appointment Reminders/Communications

Other Examples of Permitted Uses and Disclosures of Health Information: Public health activities**;** Uses and disclosures permitted or required by law (*course proceeding, workers compensations, etc).*

Activities You Can Object To

In many circumstances, you may have the chance to object before we do the following: Disclosure of information to family members, friends, or others involved in your care.

Activities That Require Your Written Permission (Authorization)

If MFC needs to use or disclose your health information for other purposes that are not listed above, we must first receive your written authorization.

Your Patient Privacy Rights: You have the right to: Request how we contact you; Inspect, and receive a copy of, your medical and billing records**;** Request corrections to your medical and billing records**;** Request restrictions on uses and disclosures of your health information. (We may not be able to grant requests beyond what the law requires).

ADDITIONAL PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that we amend your record; requesting restrictions on what information from your Clinical Record is disclosed

to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and our privacy policies and procedures. We are happy to discuss any of these rights with you.

MINORS & PARENTS

Patients under 18 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records.

BILLING AND PAYMENTS

You will be expected to pay for each visit at the time it is held, unless we agree otherwise. It is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and we are not attorneys. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

The laws and standards of our profession require that we keep Protected Health Information about you in your Clinical Record. Except in unusual circumstances that involve danger to you and/or others or where information has been supplied to us confidentially by others. You may examine and/or receive a copy of your Clinical Record if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them in our presence. The law allows us to collect a fee prior to release of copies your records to you. If we refuse your request for access to your records, you have a right of review, which we will discuss with you upon request.

INSURANCE REIMBURSEMENT

If you have a health insurance policy, we will fill out forms and provide you with whatever assistance we can in helping you receive the benefits to which you are entitled; however, **you (not your insurance company) are responsible for full payment of our fees. It is very important that you find out exactly what health services your insurance policy covers.** You should also be aware that your contract with your health insurance company with references to all inclusions and exclusions applied to your policy. We will provide you with information relevant to the services that we provide to you. We are required to provide a clinical diagnosis. Sometimes we are required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, we will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any report we submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Signed: ____Date______________________

PATIENT CONSENT FORM:
I understand that under the HIPAA act of 1996, I have certain rights of privacy regarding my protected health information. I understand that this information can and will be used to: conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly or indirectly; obtain payment from third party; conduct normal healthcare operations such as quality assessments and Physician and Physician certifications.

I have been informed by you of the above notices of privacy practices. I have been given the right to review this notice prior to signing this consent. I understand that this organization has the right to change its NOTICE OF PRIVACY PRACTICES from time to time and that I may contact this organization at any time at the address noted below to obtain a copy. I understand that I may request in writing that you restrict how my private my privacy information is used or disclosed to carry out treatment, payment, or health care operation. I also understand this organization **is not required** to agree with my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient name: ____

Signature: ____

Relationship to patient: ____

Date: ____

I, ____, in realize that any account not paid within thirty (30) days could be subject to a Bill Process Fee of $1.00 per month and/or an interest of 12% per annum. I realize that I am financially liable for these fees unless disputed with the provider or their billing agency, Atlas Billing, Inc.

Patient/ Guarantor Signature: ______________________________Date:___________________