Patient Hippa Consent Form

Our notice of Privacy Practice Information about how we may use and disclose protected information with you. The notice contains a Patient's rights section describing your rights under the law. You have the right to request notice before signing this consent. The terms of the notice may change if we change Our notice, you may request a copy by contacting the office. You have the right that we restrict how protected information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form you consent to our use and disclosure of protected health information about you for treatment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance of your consent. The Practice provides this form to comply with the Health Insurance Portability Act of 1996 (HIPPA).

The Patient understands that:

*Protected information may be disclosed or used for treatment, payment, or health care operations.

*The Practice has a Notice of Privacy Practices and that the patient had the opportunity to review this Notice.

*The patient has the right to restrict the uses of their information but the practice does not have to agree to those restrictions.

*The Patient may revoke the Consent at any time and full disclosure will then cease.

*The practice may condition receipt of treatment upon the restriction of the Consent.

Signed:____ Date:___________
Witness____(Practice Representative)

Practice Policies:

1. We request at least 24 hours cancellation notice. Failure to call, No shows, will be charged 25.00 that is not billable to insurance.
2. Our office strives not to over schedule or make patients wait, however, due to unforeseen circumstances that may occur, we cannot always guarantee that you will be seen on time. If the waiting time approaches 30 minutes, we may attempt to notify our patients and re-schedule them.
3. CO-PAYS AND DEDUCTIBLES ARE DUE AT THE TIME SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE PREVIOUSLY.
4. We will verify your insurance and file it for you, however, your insurance is a contract between you, your employer, and the insurance company. In most cases, Dr. Mach is not a party to that contract, therefore we cannot GURANTEE a specific payment amount from your insurance carrier. Any balance over 90 days past due, regardless of insurance responsibility, is due and payable by the patient. You will be informed of any past due balances so that you may contact your insurance company. Texas laws require insurance companies to pay with 30 days of receipt of a claim.
5. We attempt to either call, text or email you to remind you of your appointments, but the responsibility to keep the appointment is yours.
6. All returned checks or declined debit/credit card transactions will be charged a 25.00 administrative fee.

Signed:____ Date:___________