Tri State Mountain Neurology Associates, PC (TSMNA)
HIPAA, Authorization and Financial Payment Policy

Name of Patient: _____

Date of Birth: _____

Name of Primary Care Physician: _____

HIPAA Notice of Privacy Acknowledgment

I have been provided with a copy of the Notice of Privacy Practices from TSMNA detailing how my health information may be used and disclosed as permitted under federal and state law and outlining my rights regarding my health information. I understand that I may request in writing, how, and to whom, my information may be used or disclosed. I release TSMNA from any and all liability that may arise from the release of information given or obtained using the methods as follows:

X_____ You may contact me at work _____ Leave message? Yes No

X_____ You may call me on my cell phone_____ Leave Message? Yes No

X_____ You may call me at home _____ Leave Message? Yes No

I authorize TSMNA to speak to or leave a message with the following regarding my healthcare:

_____	_____	_____
Name	Phone Number	Relationship to patient
_____	_____	_____
Name	Phone Number	Relationship to patient
_____	_____	_____
Name	Phone Number	Relationship to patient

Authorization to Obtain and/or Release Medical and Pharmacy Records

I hereby authorize all physicians, health care entities and pharmacies participating in my health care to obtain, release, use and disclose my entire medical record by mail, phone, fax and electronic transmission in order to carry out my treatment, payment, and healthcare operations.

Confirmation of Appointments and No Show/Cancellation Fees

I understand that I must give TSMNA no less than 24 hours notice if I wish to cancel or reschedule an appointment or be subject to a $50 no show fee**. I would like to be notified of upcoming appointments using any, or all of the following methods:**

TEXT using cell number _____ **EMAIL** address _____

VOICE using phone number_____ **Enroll in patient portal?** Yes No

Authorization to Assign Insurance Benefits, Information Release and Financial Payment Policy

I authorize the payment of medical benefits (including Medicare and Medicaid) be made, on my behalf, directly to TSMNA for any services furnished to me by TSMNA and its providers and staff. I understand that I am financially responsible for any amount not covered by my insurance. I authorize release to my insurance company (including Medicare and Medicaid) any and all information concerning health care, advice, or treatment provided to me necessary for processing my insurance claims. I understand that is my responsibility to assure that TSMNA is provided with updated insurance information. I agree to pay any balances due in full within 90 days of the date of service and I understand that if my account is turned over to collections after 90 days, I agree to pay any and all collection fees including attorney fees, legal fees and court costs.

_____ _____

Signature Date

HIPAA April 2022