Office of Paul H. Deutsch M.D., R.Ph., LLC

HIPAA PRIVACY NOTIFICATION / DISCLOSURE TO FAMILY AND FRIENDS

_____

First Name Last Name Middle Initial

Primary Phone: _____ Date Of Birth: _____

We may need to contact you by phone about results, appointments, or referrals. You may request the list of people involved with your care be expanded or restricted. You have the right to amend this information at any time. To facilitate contacting you in a timely manner and to comply with federal HIPAA regulations, please complete the information below.

_____ You may only speak to me personally.

_____ You may call me at work. Work Phone: _____ Ext. _____

_____ You may call my cell phone. Cell Phone: _____ Text: YES / NO

_____ You may leave a message on my answering machine or voice mail regarding those items checked below at:

_____ Home _____ Work _____ Cell

_____ You may leave a message with the following members:

___ Spouse/Name: _____Phone: _____

___ Children/Name: _____Phone: _____

___ Parent/Name: _____ Phone: _____

___ Other/Name: _____Phone: _____

RX HISTORY CONSENT

- *By signing below, I agree to allow Paul H. Deutsch M.D., R.Ph., LLC to review any prescription history available to my electronic health record.*

FINANCIAL

- *In the event my account is referred to an attorney or collection agency for collections I agree to pay for processing or convenience fees if required as a cost of collection of my account. I understand that such fees would only be incurred if I optionally choose to pay the account by credit card or check by phone to the attorney or agency.*

I understand that this office may bill my insurance carrier/government program as a courtesy to me but that I am financially responsible for all fees incurred and I agree to pay them in full. I assign all benefits payable to me by my insurance carrier/government program to Paul H. Deutsch M.D., R.Ph., LLC.

I allow a photocopy of my signature to be used to process my insurance/government program claims for my lifetime. I understand that it is my responsibility to understand which treatment options are and are not covered by my health care policy and what I am required to do to secure those benefits.

PRIVACY PRACTICES (HIPAA)

- *By signing below I acknowledge that I was provided with the Notice of Privacy Practices.*

I understand that Paul H. Deutsch M.D., R.Ph., LLC will make reasonable efforts to accommodate this request for as long as I am a patient; but I can request a change at any time. I further understand that in some emergency situations, my protected health information may be released.

_____ _____

Patient/ Parent/ Guardian Signature Date