NOTICE OF PRIVACY POLICY-ACKNOWLDGEMENT FORM

_____ _____

PATIENT'S NAME DATE OF BIRTH

_____

PATIENT'S TELEPHONE **(**BEST NUMBER TO REACH YOU==Home-Cell-Work==**)**

_____

PATIENT'S E-MAIL Office will use your email to notify you of normal results, confirm appoint, or contact you.

HOW DO YOU WISH TO RECEIVE NOTIFICATIONS: POSTAL MAIL OR E-MAIL

Our Notice of Privacy Practice provides information about how we may use and release or not release health information about you. You have the right to review our notice before signing this consent. As provided in our notice, any revisions will be posted with the revised date. Patient has the right to notice in the event of a breach. Office will abide by the patient's request to restriction to health plan submission if patient has submitted a written request, patient has paid out of pocket and in full for that visit requested. Any breach of information the patient will be contacted at the above listed number.

I have received information about the NJ Immunization System and understand the purpose of this program, for reminders and to keep a central record. I understand that the immunization record sent to NJIIS may be share with authorized healthcare providers, schools, public health agencies, health insurance companies and other permitted by NJ Law. Pine Street Family Practice NJIIS enrollment site is 9894. Equivalent to Consent Form IMM32.

You have the right to request that we restrict how your health information is used or released for treatment, payment or health care operations and you have the right to revoke this consent, in writing. We are not required to agree to this restriction, but if we do, we are bound by our agreement, except where we have already made disclosures on your prior consent.

By signing this form, you are aware of our use of your protected health information for your medical treatment, NJIIS, payment and health care operations.

_____ _____

SIGNATURE **DATE**

_____

PRINT NAME

☐I give my permission for the following person/persons to inquire about my medical information

_____ _____ _____ _____

Relationship _____ _____ _____ _____

It is important to understand that by signing this release it entitles the above person to receive ANY and ALL of your information.

☐**I do not give my permission for anyone to receive my results.**

_____ _____

SIGNATURE **DATE**

ALL CHARGES WILL BE SENT TO YOUR INSURANCE COMPANY WITH THE INFORMATION YOU SUPPLY OUR OFFICE. COPAYMENTS ARE DUE WHEN SERVICES ARE RENDERED TO YOU. PAYMENT FROM YOUR INSURANCE COMPANY SHOULD BE MADE WITHIN 30 DAYS. THE PATIENT / GUARDIAN IS RESPONSIBLE FOR OUTSTANDING CHARGES. A COLLECTION FEE OF $25.00 OR 25% IF THE OUTSTANDING BALANCE EXCEEDS $75.00 WILL BE INCURRED AFTER THIRTY DAYS OF NONPAYMENT. RETURNED CHECK FEE IS $25.00.

_____ _____

SIGNATURE **DATE**

WHOM MAY WE CONTACT AS AN ALTERNATE NUMBER?_____

CONTACT # _____ RELATIONSHIP_____

WE RESERVE THE RIGHT TO CHARGE FOR APPOINTMENTS CANCELLED OR BROKEN WITHOUT 24 HOURS ADVANCE NOTICE.

NOTICE OF PRIVACY WILL NOT EXPIRE UNLESS WRITTEN REQUEST OF CHANGE OR VOID IS SUBMITTED, PATIENT BECOMES OF AGE AT 18 AND MUST SIGN ON THEIR OWN BEHALF.