NOTICE OF PRIVACY PRACTICES AKNOWLEDGEMENT

Pediatric Offices at Willow Bend
6529 W. Plano Pkwy Suite B
Plano, Texas 75093

I understand that under the Health Insurance Portability & Accountability Act of 1996, (HIPPA) I have rights to 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 the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. 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 above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient name _____

Parent/Guardian name _____

Relation to Patient _____

Signature_____Date_____

OFFICE USE ONLY

I attempted to obtain the Patients signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as so documented below.

Signature_____Date_____

Reason_____

EXPLANATION OF PAYMENT AND INSURANCE FILING PROCEDURES

Our office is pleased to assist you in filing claims with your insurance company for reimbursement of your expenses. We will wait ninety (90) days for your insurance company to pay your claim. If they deny your claim and/or do not pay your claim for any reason, any remaining balance must be paid by you within thirty (30) days. We will not fight your insurance company for payment. We file insurance for you as a courtesy.

- It is the patient's responsibility to pay any deductible, co-insurance, and/or co-payments at the time services are rendered.
- Our office NEVER guarantees that your insurance will pay. We will make every attempt at the beginning of your health care to receive verification of your policy benefits. However, if for some reason your insurance claim is denied, you are responsible for the amount due on your account immediately.
- We recommend that you also contact your insurance company to verify coverage on your policy.
- We will not file insurance for patients that do not live in Texas. We will provide you with a receipt of all services rendered.
- If peakflow, oxygen saturation or specimen handling are recommended for your treatment in our office, please be aware that they may be applied to a deductible under your plan benefits.
- Our office will not file with a secondary insurance policy.
- There will be a $25 fee on all returned checks. Checks will not be presented to the bank twice.
- You may receive a copy of your records at any time with a written request. There is a $25 fee for all records received by our office. Allow 30-45 business days to be completed. Shot record copies are available with checkup. There will be a $5 fee for subsequent requests of copies.

I fully understand the above policies and agree to them. I understand that I am responsible for payment to Dr. Sharon L. Wiener and/or Associates for all charges incurred by myself, regardless of my insurance coverage. For your convenience, we accept Cash, Visa, Master Card, American Express, Discover, and personal checks (with proper identification) as methods of payment.

CONSENT FOR TREATMENT

I give permission to the physician and whomever she may designate as his assistant(s)/associate(s) to administer such treatment as is necessary, and to perform any medical care or procedures as are considered therapeutically necessary based on findings during examination or treatment.

AUTHORIZION TO RELEASE INFORMATION

I hereby authorize Dr. Sharon L. Wiener and/or Associates to release any medical information pertaining to the examination, treatment, history, prescription of medications, and medical expenses of myself to any physician, hospital, clinic, insurance company, and all other agencies deemed necessary in order to process insurance claims. This authorization also includes the release of any pertinent medical information to any specialist or other medical facility the physician may refer the patient to for medical treatment or evaluation.

ASSIGNMENT OF BENEFITS

I authorize payment of medical benefits to Dr. Sharon L. Wiener for services rendered. I understand that I am financially responsible for any co pays, co-insurance, or deductibles required by my insurance company. I also understand that I am responsible for charges that are not covered by my insurance company.

By my signature I agree to comply with the Financial Policy, Consent for Treatment Policy, Notice of Financial Interest, Authorization to Release Information Policy, and Assignment of Benefits.

_____ _____

Insured's or Authorized Person's Signature Date