

A: Notifier(s): SI Medical Inc

B: Patient Name: _____ **C: Chart Number:** _____

Advanced Beneficiary Notice of Non-Covered Commercial Insurance

NOTE: If your insurance company pays on a claim, and in the future determine that services rendered are not a covered service they may demand a refund from SI Medical Inc. If this should occur you will be responsible to reimburse SI Medical, Inc.

If your insurance company denies payment for the services below, you may have to pay for these services, procedures or supplies. You and your health care provider may feel there is a need for this service, procedure or supply. We expect your insurance may not pay for the item/items listed below.

D: Service provided	E: Reason for the Denial	F: Estimated Cost
_____ B6/B12 injection	Non-Covered Item	\$ 20.00
_____ Administration Fee	Non-Covered Item	\$ 40.00
_____ Exam	Non-Covered Item	\$
_____ Other	Non-Covered Item	\$

WHAT YOU NEED TO KNOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the services in box D listed above.

G: OPTIONS: Check only one box. We cannot choose a box for you.

_____ **OPTION 1.** I want the service(s) checked in part D listed above. You may ask to be paid now but I also want my insurance billed for an official decision on payment. I understand that I am responsible for payment.

_____ **OPTION 2.** I want the item(s) listed in part D, but do not bill my insurance. Payment is expected at the time of treatment.

H: Additional Information:

Signing below, means that you have received and understand this notice. You will also receive a copy. This document is good for ONE year.

I: Signature: _____ **J: Date:** _____

REGISTRATION INFORMATION

PATIENT INFORMATION

First Name: _____ MI: _____ Last Name: _____
Street Address: _____ City: _____ State: _____ Zip: _____
Sex: M F Date of Birth: _____ Age: _____ Marital Status: Single Married Divorced Widowed Separated
Employer and Employer's Address: _____
Work Phone: _____ Home Phone: _____ Email: _____
Student Status: Full Time: Part Time Name of School: _____ Social Security: _____

RESPONSIBLE PARTY INFORMATION

If you are the responsible party mark "self" and move down to "Insurance Information".
Patient's relationship to responsible party: Self Spouse Dependent

First Name: _____ MI: _____ Last Name: _____ Social Security: _____
Street Address: _____ City: _____ State: _____ Zip: _____
Sex: M F Date of Birth: _____ Age: _____ Marital Status: Single Married Divorced Widowed Separated
Employer and Employer's Address: _____
Work Phone: _____ Occupation: _____

PLEASE ATTACH YOUR INSURANCE CARD WITH THIS PAPERWORK.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I certify that I have received a copy of Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of **SI MEDICAL, INC/CLINICANYWHERE, LLC** health care operations. The Notice of Privacy Practices also describes my rights and **SI MEDICAL, INC/CLINICANYWHERE, LLC** duties with respect to my protected health information. The Notice of Privacy Practices is posted at the front desk and a copy was supplied to me at registration.

SI MEDICAL, INC/CLINICANYWHERE, LLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail OR asking for one at the time of my next appointment.

Signature _____ Date: _____

Printed Name _____ Self Parent of Patient

ASSIGNMENT AND RELEASE

I hereby assign, transfer, and set over to **SI MEDICAL, INC/CLINICANYWHERE, LLC** all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient's Signature _____ Date _____

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

HIPAA is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

OUR PLEDGE REGARDING YOUR MEDICAL INFORMATION

We respect our legal obligation to keep health information that identifies you private. As obligated by law, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We do not use your health information in our office or disclose it outside of our office without your written permission. In some limited situation, the law requires us to disclose your health information without either a written or verbal consent.

Use and Disclosure With Consent

We will ask you to sign a consent form allowing us to use and disclose your health information for purposes of treatment, payment and healthcare operations in this office. We are allowed to refuse to treat you if you do not sign the consent form.

We are permitted to use and disclose your healthcare records for the purpose of treatment, payment, and healthcare operations.

- Treatment means providing coordination, or managing healthcare related services by one or more healthcare providers. For example, we may need to share information with other providers or specialists involved in your care.
- Payment means activities as obtaining reimbursement for services, verifying coverage, billing or collection activities and utilization review. For example, we disclose treatment information when billing a medical plan for your physical therapy services.
- Healthcare operations include the business aspects of running our practice. For example, patient information may be used for training purposes or quality assessment.

Unless you request otherwise, we may use or disclose health information to the extent necessary to help with your healthcare or with payment for your healthcare. In addition, we may use your confidential information to remind you of your appointments by leaving messages at home and/or work. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

Use and Disclosure without Consent

In some limited situations, the law requires us to use and disclose your health information without your permission. These examples may never come up at our office at all, but such disclosures are:

- When a state or federal law mandates that certain health information be reported for a specific purpose.
- For public health purposes, such as contagious disease reporting and notices to and from the FDA regarding drugs and medical devices.
- Disclosure to government authorities about victims of suspected abuse, neglect or domestic violence.
- Uses and disclosures for health oversight activities, such as for the audits by Medicare, or for investigation of possible violations of healthcare laws.
- Disclosures in response to subpoenas or orders of the court.
- Disclosures for law enforcement purposes, such as to provide information about someone who is suspected to be a victim of a crime, or to provide information about a crime at our office.
- Disclosure related to worker's compensation programs.

Your Rights Regarding Your Health Information

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to the disclosure of family members, other relatives, close personal friends, or any other person identified by you. We are however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to ask us to communicate to you in a confidential way, such as by phoning you at work rather than at home or by mailing health information to a different address. Please provide a written request.
- The right to ask to see or to get photocopies of your health information. You may have to pay for photocopies in advance. We do charge a fee to release your records to an outside source other than a healthcare provider (examples are lawyer, healthcare research firm, etc). Please complete our written records request for billing or medical record release.
- The right to receive an accounting of disclosures of protected health information.
- The right to amend your protected health information.
- The right to obtain a paper copy of this notice from us upon request.

This notice is effective as of January 1, 2014, and we are required to abide by the terms of Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practices from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health and Human Services, Office of Civil Rights, in the event you feel that your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our privacy practices:

Tracy Askari, Practice Administrator
SI Medical Inc.
1909 W Coolidge Ave
Marion IL 62959-1097
(618) 997-5677

For more information on HIPAA or to file a complaint:

The US Dept of Health & Human Services
Office of Civil Rights
200 Independence Ave. SW
Washington DC 20201
877-696-6775 (toll free)

This notice has been issued and considered effective date signed. This copy shall be retained by the department for a minimum of six (6) years.

Signature of Patient or Legal Representative

Date