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**HIPAA Compliance – Notice of Privacy Practices**

We are required by law to provide this Notice to you and obtain your written acknowledgement of receipt before providing any services to you. You may read a copy of the Notice posted in our manual in the waiting room.

Please feel free to ask any questions you may have about the contents and/or request a copy of the Notice at any time.

**HEALTH CARE INFORMATION RIGHTS – You have the right to:**

Inspect and request a copy of your records

Request an amendment

An accounting of disclosures

Request restrictions on certain uses/disclosures

Receive a written copy of our Notice of Privacy Practices

**HOW TO FILE A COMPLAINT ABOUT OUR PRIVACY PRACTICES**

This section tells you what you can do if you believe your rights have been violated.

You will not be penalized for filing any complaint.

**HOW WE MAY USE/DISCLOSE YOUR HEALTH INFORMATION WITHOUT YOUR AUTHORIZATION**

The law permits these types of uses and disclosures because it assumed you would want this information disclosed for these purposes or because such disclosure is acknowledged as critical for the functioning of our health care system. We are allowed to disclose any personal health information in regards to treatment, payment, and health care operations.

Maintaining the privacy of your health information is very important to us. We will make every attempt to protect the privacy of your information in compliance with the HIPAA guidelines and ensure that your information is not used or disclosed unnecessarily.

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**HIPAA Compliance – Notice of Privacy Practices Consent**

**I affirm that I have received a copy of ARCKC LLC’s Notice of Privacy Practices.**

**I give permission for ARCKC LLC to: (select from the following)**

\_\_\_\_ Leave appointment reminder with person/answering machine at phone \_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Leave appointment reminders as text messages at phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Leave patient portal information at my email address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Discuss payment, insurance, billing, and accounting issues with:

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Share medical information with family members only in emergency situations.

\_\_\_\_ Share medical information upon their request with my spouse: Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Share medical information upon their request, unless I direct you not to share certain information with:

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent/Guardian Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**INSURANCE ASSIGNMENT –Please read and sign the following**

I hereby authorize ARCKC LLC to furnish information to insurance carriers regarding my illness and treatment, and hereby assign to ARCKC LLC all payments for medical service rendered to me. A photocopy of this authorization and assignment shall be as binding as the original.

**Patient signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_**

**MEDICARE/Medicaid PATIENTS ONLY**

I request that payment of authorized Medicare/Medicaid Benefits be made either to me or on my behalf to ARCKC LLC for any services furnished to me by these physicians. I authorize any holder of my medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

**Patient signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent/Guardian signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_**