ARCKC LLC

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** _____________

ARCKC LLC

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.