PATIENT RELEASE OF INFORMATION

(HIPAA RELEASE)

I _____ give my permission to release any of my medical information to the following persons listed below. This may include family members, friends, and / or associates.

If you choose to not allow anyone access to your medical records, Please write "NONE" and sign and date.

Name	Contact Number

_____ _____

Signature of Patient Date

Please Circle **Either** Do **OR** Do Not On Each Of The Following Sections

I _____ (DO / DO NOT) give my consent for lab results and diagnostic test results to be sent electronically to my **Patient Portal** using the following email address: _____.

I _____ (DO / DO NOT) give my consent for lab results and diagnostic test results to be left on my answering machine / voice mail at the following phone number: _____.

_____ _____

Signature of Patient Date

I understand that both of these authorizations, if signed, are effective for one year from the date signed and that I am to notify Coppell Associates In Family Medicine of any changes I wish to make to this authorization.

Conditions of Admission

Consent for Treatment- Release of Information

I consent to Treatment for the care of the patient indicated on this form. Authorization is hereby granted to release information as may be necessary to process and complete my insurance claim. **I am also consenting to the release of my information for Electronic Medical Records; including but not limited to, electronic prescribing, downloading insurance benefits, medication history, etc.**

Date:_____ Signed: _____

Relationship to patient: _____

Assignment of Insurance Benefits

I hereby assign, transfer and set over to COPPELL ASSOCIATES IN FAMILY MEDICINE P.A. all of rights, title and interest in my medical reimbursement benefits under my insurance company. This assignment shall remain valid until written notice is given by me.

Date:_____ Signed: _____

Relationship to patient: _____

Thank you for choosing COPPELL ASSOCIATES IN FAMILY MEDICINE P.A. as your healthcare provider. We appreciate the opportunity to assist you with your health care needs.

Our primary objective is to provide quality patient care in an office setting (and hospital when appropriate). We offer complete Family Practice. In order to better assess your medical needs, we will not do referrals without evaluating you in the office to determine if you actually need a referral or have a problem we can take care of. If you need a referral, we can better determine who/what specialty would be most appropriate, we cannot diagnose your condition over the phone. Please allow 2 weeks for the referral process.

On the business side, in order to continue providing quality patient care, payment in some form must be received from each patient to whom services are provided. We are on several managed care plans that we will be happy to file for you. As a condition of accepting your insurance in lieu of payment in full, all copay fees and deductible/co-insurance amounts not satisfied per your insurance company are due at the time of service. Payments from your insurance company are expected within 45 days. After 60 days without a payment from your insurance company or any notification of information needed from them, we will look to you for payment in full.

Because it costs us $10 per statement sent to each patient, we will be adding this as a late charge after 90 days after the first statement of your balance due without the balance being paid.

If you are not on one of the managed care plans for which we are providers, payment in full is expected at the time of service. We will provide you with a statement with the information necessary to bill your carrier. We only bill your primary insurance carriers - we will provide you with a statement and any information necessary for you to file your secondary carrier.

To help us provide care to people who need it, we ask that you cancel your appointment at least 24 hours ahead of time. If you do not, there will be a $30.00 charge for no shows and less than 24-hour cancellations.
Please be advised, that after 3 NO SHOW VISITS WITHIN ONE YEAR, you could be discharged.

It is up to you to know your insurance coverage. Guarantor is responsible for giving us the patient's current insurance information, or they will be responsible for paying those charges. Guarantor is responsible for patient's co-pays, any non-covered or denied services, deductibles and/or co-insurances deemed "patient responsibility" by your insurance carrier. This includes anything done in our office as well as lab work or other diagnostic testing. If you have any questions regarding what your insurance covers, you should contact your insurance carrier for details on your specific plan.

Thank you again for your trust in our practice and your cooperation with our payment policy.

Patient Name:_____ Signed: _____

Date:_____ Relationship to patient: _____