WHAT IS HIPAA?

HIPAA IS THE ACRONYM FOR THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT THAT WAS PASSED BY CONGRESS IN 1996. HIPAA DOES THE FOLLOWING:
PROVIDES THE ABILITY TO TRANSFER AND CONTINUE HEALTH INSURANCE COVERAGE FOR MILLIONS OF AMERICAN WORKERS AND THEIR FAMILIES WHEN THEY CHANGE OR LOSE THEIR JOBS;REDUCES HEALTH CARE FRAUD AND ABUSE; MANDATES INDUSTRY-WIDE STANDARDS FOR HEALTH CARE INFORMATION ON ELECTRONIC BILLING AND OTHER PROCESSES; AND REQUIRES THE PROTECTION AND CONFIDENTIAL HANDLING OF PROTECTED HEALTH INFORMATION. I HAVE BEEN OFFERED AND RECEIVED A COPY OF THE HIPAA FORM BY RELIABLE MD. I HAVE BEEN ASKED TO REVIEW THE INFORMATION AND GIVEN THE OPPORTUNITY TO ASK QUESTIONS IF I AM UNCLEAR ABOUT THE MEANING OF THE INFORMATION.

E-MEDICATION HISTORY DOWNLOAD

The Medication History services allows prescribers and pharmacies to use the Surescripts Network to access a patient Medication History across providers, at the point of care. This service can be used while providing routine care, as well as during emergencies (like natural disasters). In both cases, Medication History enables healthcare providers to make a more informed clinical decision. To provide this service, Surescripts securely connects to a patients medication history data stored in the database of community pharmacies and pharmacy benefit managers. Surescripts requires patient consent as part of the process a prescriber must go through each time they electronically access a patient medication history If a request for medication history is sent to Surescripts and the patient consent flag is not set, Surescripts rejects the request. I hereby provide RELIABLE MD, the ability to download my complete Medication History from the nationwide database of pharmacies.

CANCELLATION/NO SHOW POLICY

The cancellation/no show policy is a courtesy to the office and patients. Canceling or rescheduling an appointment must be done a minimum of 24-hours prior to your appointment date whenever possible. Per office policy missed appointments and rescheduled within this 24-hour period are subject to a $50 fee. Reliable MD reserves the right to decline any future appointments after two occurrences and if no payment arrangement has been made or you may be discharged from the practice. NOTICE: Please be courteous to the office and arrive on time for your appointments as those that are more than 10 minutes late may be subject to rescheduling at the discretion of the practice manager.

REQUEST FOR CARE & CONSENT

The undersigned consents to the medical care and treatment, as it may be deemed necessary or advisable in the judgment of my licensed care provider, which may include but are not limited to laboratory, x-ray examination, medical or surgical treatment or procedures, anesthesia, or other services rendered to the patient under the general and special instructions of the patient's licensed care provider Reliable MD has the right to refuse to see you if you refuse to sign the consent or if at any time you choose to revoke this consent.

ASSIGNMENT OF BENEFITS

I request the payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, may be made on my behalf to Reliable MD for any medical services provided to me by the organization (including in person and tele-visits). I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equivalent or services to the organization, the Health Care Financing Administration, my insurance carrier or other insurance carrier or other medical entity. A copy of this authorization will be sent to the Health Care Financing Administration, my Insurance company or other entity if requested. The original will be kept on file by the organization. I understand that I am financially responsible to the organization for any charges that are not covered by my health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting responsibility as explained above for all payment for products received.

OFFICE POLICY FOR PAYMENT

Payment is expected IN-FULL at the time of rendered services by the patient or the person accompanying the patient. If our office is a participating provider with your health insurance carrier, all non-covered services, co-pays and or deductibles will be collected at the time of each visit. Arrangements for anything other than full payment at the time of service must be made prior to your appointment. It is the responsibility of the guarantor to understand and accept the guidelines set up within the individuals insurance plan. If you are unable to provide us with complete insurance information at the time of your visit you will be responsible for payment of services IN-FULL. I understand that I am financially responsible for any balance not covered by any insurance carrier. I further understand and agree, that if I fail to make timely payments on my account, I will be responsible for any and all reasonable costs of collection, including billing fees as well as reasonable attorney's fee.