COASTAL FOOT & ANKLE SPECIALISTS

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

Allowed Uses and Disclosures of your Medical Information:

- Treatment, such as ordering diagnostic tests
- Payment, such as submitting billing information to your insurance company
- Health care operations, such as quality assurance review, coordination of care, eligibility verification
- Your medical information may be used or disclosed for emergency treatment; when we are required by law to treat you, we attempt to obtain consent, and are unable to do so; we are unable to obtain consent due to substantial communication barriers and consent for treatment is implied under the circumstances; or we created or received the information in treating an inmate.

You have the right to:

- Request restriction on certain uses and disclosures, however, we are not required to agree
- Receive confidential communications from us, upon written request
- Inspect and request copies of your medical information
- Request to amend incorrect or incomplete medial information
- Receive an accounting of any disclosures made, upon written request
- Receive a paper copy of the notice upon request

We are responsible for maintaining the privacy of your medical information, providing you with this notice and abiding by the terms within, and providing written notice of any change of this notice.

Authorizations: Upon your authorization, we may disclose your medical information, including X-rays and billing information, to a requesting entity, such as an attorney, another provider, or a relative. Unless otherwise specified, we reserve the right to release as much information as we feel necessary pertaining to the request. You may revoke any authorization you make anytime in writing, except the extent it was already relied on.

Patient contact: We may contact you to provide appointment reminders, treatment information, billing and payment information, or for patient satisfaction surveys.

By signing this I acknowledge that I was provided a copy of the Notice of Privacy Practice

Patient Name (Please Print)	Signature	Date

Parent, Guardian, or Patient's legal representative	Name(s) of those we may release your medical information to (Please Print)

- ✓ It is our policy to collect all copays and outstanding balances *prior* to services rendered.
- ✓ Please give *24 hour notice* for appointments that need to be canceled, we will happily reschedule you
- ✓ We require you update personal and insurance information for claims processing. If you require a referral or authorization, it is your responsibility to obtain and keep this current.

By signing this I acknowledge that I read and understand the office policies.

Patient Name (Please Print)	Signature	Date