

East Flagstaff Family Medicine, LTD

**Notice of Privacy Practices (NPP) Policy and Financial Policy
Effective Date of Policy: April 1, 2003
(Revised 1/1/2008)**

Every Patient will receive a Notice of Privacy Practices (NPP):

- If you do not receive the Notice of Privacy Practices, it can be mailed to you.
- You also have the choice of receiving the Notice of Privacy Practices via e-mail.
Every effort will be made in order that each patient receive a Notice of Privacy Practice on his or her first date of service or after 4/13/03 and all efforts will be documented in writing.

This office will comply with all aspects as printed in our Notice of Privacy Practices and our privacy notice will be in compliance with all appropriate laws and regulations, federal, state, and local.

By signing below:

1. I understand that if I provide false Insurance information I can be held accountable and prosecuted as law provides.
2. I hereby authorize the undersigned physician to release any information acquired in the course of my examination or treatment to referring physician or insurance company provided by me.
3. I understand that if I request a phone call from my Provider of medical service I may be charged. This is payable by me and will not be billed to my insurance company.
4. Prescription request made by myself or my pharmacy on my behalf, without an office visit, may be charged
5. Additional billing statements sent to me after 60-days outstanding will include an \$8.00 fee for rebilling administrative costs.
6. I hereby authorize East Flagstaff Family Medicine to obtain, in my behalf, any insurance information covered by "The Privacy Act" from my insurance company(s) file(s). I hereby authorize payment directly to the physician(s) for medical and/or surgical benefits.
7. I have received a copy of the Notice of Privacy Practices and it was given to me on my first visit to East Flagstaff Family Medicine on or after 4/13/03.
8. I understand that my credit card number will be kept on file at East Flagstaff Family Medicine that I may authorize for charges incurred for services rendered.
9. If my account is turned to an attorney or collection agency I will be responsible for all charges incurred.
10. I am not a Medicare or Medicare replacement beneficiary nor will be within the next twelve months. I will advise East Flagstaff Family Medicine if I become Medicare eligible.
 I am a Medicare or Medicare replacement beneficiary and have signed the contract for self pay fee schedule.

The financial policy of East Flagstaff Family Medicine has been fully explained to me and I acknowledge full responsibility for all charges incurred, regardless of possible insurance coverage.

Date: _____ Signature: _____

Print: _____