East Flagstaff Family Medicine, LTD

Notice of Privacy Practices (NPP) Policy and Financial Policy
Effective Date of Policy: April 1, 2003
(Revised 7/11/16)

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:

I acknowledge receipt and have read and understand the Notice of Health Information Practices regarding my providers' participation in The Network, the statewide Health Information Exchange (HIE), or I previously received this information and decline another copy.

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 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. Obtain And Authorize EFFM to obtain additional pharmacy benefit information as well as medication History.
4. 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.
5. If my account is turned to an attorney or collection agency I will be responsible for all charges incurred.

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: _____