Financial Agreement & Notice of Privacy Policies

AUTHORIZATION, ASSIGNMENT OF BENEFITS, AND REFERRAL MEDICAL RELEASE
I hereby authorize the release of medical information including complete medical records, test results and billing information to my insurance company/other medical professionals/medical care institutions that I may be referred to for treatment. I understand this information may be used to review, investigate, or make payment of a claim and/or to review records for quality improvement, audit compliance and complaint resolution. I authorize payment directly to Vineyard Medical Care for all medical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-pays, co-insurance, deductibles and non-covered services. I agree to pay all collection charges including reasonable attorney fees, if necessary, to pursue payment of this account.

HIPAA CONSENT & COMPLIANCE NOTIFICATION FOR OUR PATIENTS
The Department of Health and Human Services has established a “Privacy Rule” (HIPAA) to help ensure that personal healthcare information is protected and to provide a standard for healthcare providers to obtain their patients’ consent for uses and disclosures of health information to carry out treatment, payment or healthcare operations. We support your full access to your personal medical records. You may refuse to consent to the use or disclosure of your PHI (Personal Health Information), but this must be in writing. Under this law, we have the right to refuse treatment if you choose to refuse to disclose your PHI. If you choose to give consent, at any time you may request to refuse to disclose all or part of your PHI. You may not revoke actions that have already been taken based on this or a prior consent.

The misuse of Personal Health Information is a national problem causing inconvenience, aggravation and money. We want to reassure you that our employees undergo training to understand and comply with laws and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA). We welcome your input regarding any service problem so that we may remedy the situation properly. Thank you for being one of our highly valued patients.

PRIVATE INSURANCE PATIENTS: Vineyard Medical Care accepts many major insurances, Medicare and some MA state Medicaid. You are responsible for the bill should your insurance company decline payment. It is the Patient’s responsibility to know their coverage.

HMO PLAN PATIENTS: You are required to obtain a referral from your primary care doctor for your visit. If you do not obtain the referral, you will be responsible for any charges for services rendered.

INSURANCES NOT ACCEPTED: We may provide services to patients that do not have an insurance that we are contracted with, however there is a Flat Rate Fee of $180 that is due at the time of service. A claim summary may be provided to you in order to file with your insurance plan to request reimbursement.

PATIENTS WITHOUT INSURANCE: We may provide services to patients that do not have any insurance. However, you will be expected to pay a Flat Rate Fee of $180 that is due at the time of service.

LIABILITY INSURANCE: We may provide treatment for Worker’s Compensation, Motor Vehicle or Personal Injuries. You are required to provide the claim number associated with the incident and the billing name and address.

METHODS OF PAYMENT: We accept CASH/CHECK/VISA/MC/DISCOVER/AMEX. We will NOT accept post-dated checks or hold onto checks for any length of time. Payment arrangements may be made as necessary. There is a $20 fee per returned check.

PRIOR BALANCE: If you have a prior balance at the time services are requested, you will be asked to pay that IN FULL before you are seen. If you are unable to pay in full, we may consider payment arrangements.

COLLECTION PROCESS: Members of our billing department are available to answer any questions or help make payment arrangements. Once made in writing, any agreements are binding. Failure to comply or respond to repeated communications from our office may result in immediate discharge from the practice with 30-day emergency coverage and involvement of an outside collection agency. Once referred to an outside agency, accounts must be paid in full before being seen. Our billing office can be reached at 1-800-787-1596.

NO SHOW POLICY: Any patient who fails to arrive for a scheduled appointment without canceling the appointment at least 24 hours prior to the scheduled time is considered a “no-show”. Any patient who has an initial “no-show” appointment on record will be subject to a $75 no-show fee for any additional instances (this fee is not covered or reimbursed by insurance plans.) All “no-show” patients will receive a missed appointment letter after 2 no shows. After 3 “no-shows” a patients file will be labeled as having “same-day status” only. After an established patient has more than 3 “no-show” appointments, that patient may be discharged from our practice and asked to seek healthcare with another physician. Patients seeking to establish care with VMC who fail to cancel or reschedule their initial appointments at least 24 hours prior to the scheduled appointment are also considered to be “no-shows”. The second instance of failing to keep their initial appointment as scheduled will result in denial of establishment with the practice.

I agree that I have read and understand the terms of this contract.

Patient Name (please print): ____________________ **Date of Birth:** ____________

Signature: ____________________ **Date:** ____________

If under 18, parent/guardian printed name: ____________________

Email address: ____________________ **Preferred Pharmacy:** ____________________

Emergency Contact: Name: ____________ Phone: ____________ Relationship: ____________

Vineyard Medical Care

Designate Family & Caregivers to pick up or discuss personal health information

Patient Authorization to Release Protected Health Information to Family, Caregivers or other designee(s)

I, ________________________________, ____/____/____ authorize my health care
(Print Full Name) (Date of Birth)

providers/advocates of Vineyard Medical Care to release all medical and billing information; including mental health, laboratory and diagnostic testing including HIV, to the individual(s) named below. This authorization will become part of my medical record and will remain in effect until the date of my death.

I understand that my personal medical information may further be released by the designee(s) I have listed below, if those designee(s) are not required by law under the Health Insurance Portability and Accountability Act (HIPAA) to protect the privacy of the information, or in the event the information is no longer protected by federal regulations governing privacy regulations.

I understand I am authorizing release of my protected health information to my designee(s) as provided below, and that I may revoke this authorization, except to the extent that my health care providers have already taken action based on this authorization, at any time by notifying Vineyard Medical Care in writing.

*****Please advise us in writing if there is any exception to this release*****

I understand I am under no obligation to sign this authorization; however, it is **not valid unless signed.**

Please enter information of friends, family members and/or caregivers:

Name: **Address:**

Relationship to Patient: **Home #:** **Cell#:**

Name: **Address:**

Relationship to Patient: **Home #:** **Cell#:**

Name: **Address:**

Relationship to Patient: **Home #:** **Cell#:**

________________________________ ____________________
(Patient Signature) **(Date)**