HIPAA- Privacy Policy

It is the policy of our practice that all physicians and staff members preserve the integrity and the confidentiality of protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our entire practice have the necessary medical and PHI to provide our patients the highest quality medical care possible and patients should not be afraid to provide information to our practice, physicians, staff members for purposes of treatment, payment, and healthcare procedures. Our HIPAA policy in its entirety can be obtained through our office at any time. Let us know if you would like to read the full copy prior to signing this consent.

I **have reviewed this consent from and hereby give permission to Woodstock Primary Care to disclose my PHI in accordance with these guidelines to only the Persons listed below:**

Name	Relation
Name	Relation

Office Policy on Health Insurance Plans

We are pleased to meet the needs of our patients and referring physicians by enrolling with various managed care insurance programs. While we are able to provide you with this service, it is extremely difficult to keep track of all the individual requirements of each plan. Even with the same insurance company, plans often may differ. Providing quality medical care for our patients is our primary concern, and we are more than willing to provide that care based on your insurance contract guidelines. We request at each visit that you advise us of your guideline requirements. Unfortunately, if you do not inform of any special requirements in your contract and we subsequently provide services, or order services such as lab work or hospitalization that are not covered, we or the medical facility will have no choice but to bill you directly for all said charges. All fees submitted and denied by your insurance carrier will become your responsibility.

Our practice will file insurance claims as a courtesy for you, however, office visit co-pays, co-insurance, and deductibles are payable on the day of your visit. Remember that you are responsible for all fees, regardless of your insurance coverage. Some insurance plans require prior authorization and/or referral documentation. This is your responsibility. If we do not receive the authorization and/or referral documentation in advance, payment is due at the time of service.

With your cooperation, you should be able to receive all benefits offered by your insurance plan, and we will be able to concentrate of caring for your medical needs. **Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.**

Authorization

Please initial and sign below:

_____✔ **I understand HIPAA and its policies.**

_____ **I have read and understand the office policy stated above and agree to accept responsibility as described.**

_____ **I authorize the release of medical information necessary to process a claim, to health care professionals requesting consultation, and third party payers responsible for payment of medical and surgical benefits to Woodstock Primary Care.**

_____ **I authorize Ilya Wolfson, MD to receive prescription information as supplied by health plans, pharmacies, and participating pharmacy benefit managers.**

Signature of Patient or Guardian	**Date**

Patient Financial Agreement Form

Patient Name:_____

I consent that I am responsible for (any and all) charges assigned to me by my insurance company including, but not limited to, yearly deductibles, co-insurances, co-pays, non-plan coverage, etc. _____(Patient/Guardian Initials)*

Certain insurance companies and/or policies do not cover recommended care which may include vaccinations, lab work and other procedures and services. These services, if not covered by your insurance plan, will become your financial responsibility. _____(Patient/Guardian Initials)*

I consent that I do understand and will abide by the below listed administrative fees which are enforced by Woodstock Primary Care. I agree to pay for fees accordingly. _____(Patient/Guardian Initials)*

Administrative Fees

1)	Appointments cancelled with less than 24 hour notice	$30.00
2)	Patient "NO SHOWS" for appointments	$40.00
3)	Returned payment for Non Sufficient Funds	$35.00
4)	Patient account placed with collection agency	$45.00
5)	Request for release of medical records (paper/electronic)	$25.00
6)	If patient account is unpaid for greater than 90days, a 6.5% interest charge will be applied to unpaid total owed.	**%** of Bill
7)	Completion of all patient requested forms, to include, but not limited to letters or any information requiring the Physician's signature, which includes other miscellaneous or administrative forms required by third parties, not your insurance company.	$40.00
8)	Family Medical Leave Act	$25

*Signature:_____ Date:_____

Note: *= *Patient understands Financial Requirements.*

WOODSTOCK PRIMARY CARE

Appointment Cancellation Policy

Your appointment time is important to you, your physician, and to others who are in need of our services.

If you cannot keep your appointment for any reason, please call us as soon as possible prior to your appointment time. If you do not show for your appointment or do not cancel, **a fee of $40 will be charged to your account.** You will be personally responsible for this charge. This charge will not be billed to nor paid for by your insurance company. Future appointments will not be scheduled until this fee is paid.

You will receive an appointment reminder card at your visit with the date and time for your next visit.

Please help up keep the scheduling of appointments fair for everyone.

Thank you.

_____ _____

Patient/Parent Signature Date