

James R Curtiss, MD, LLC
Health Insurance Portability and Accountability Act of 1996

**Acknowledgement of Receipt
of Notice of Privacy Practices and Patient's Right and Responsibilities**

(Please check or initial where indicated.)

_____ I acknowledge that I have been offered a copy of James R Curtiss, MD, LLC, Notice of Privacy Practices. This Notice describes how James R Curtiss, MD, LLC, may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

_____ I also acknowledge that I have been offered a copy of the Patient's Rights and responsibilities.

_____ I acknowledge the following policies on the involvement of others in my care (please read below).

A. When we call you

Please note that if we are unable to reach you personally, our office may leave messages regarding appointments or test results (as deemed appropriate) on your answering machine or with a family member who answers the phone at the number(s) given to us by you--unless you submit a written request for us not to do so. [Please see receptionist to submit any special opt-out requests.]

B. When you call us

Family members (or other care takers or representatives) calling or presenting to our office who are acting on your behalf must have your written authorization on file in order to act as your health care representative. You may designate this authorization by noting the names (and numbers, as appropriate) of authorized individuals below:

Please think carefully about the extent to which others are (or may become) involved in your health care and designate the appropriate individuals. Please note that any individuals you designate may be required to verify information about the patient prior to any release of information. Should you choose to leave this designation blank, our office will speak only to you, the patient, regarding your health care, except as outlined in Item A.

I acknowledge that I have read and understand the information listed or referenced above.

Signature of Patient or Personal Representative

Date _____

Relationship to Patient (if Representative)

James R Curtiss, MD, LLC

General Consent/Financial Agreement/Release of Medical Records

Financial Responsibility

_____ I acknowledge that my insurance is an agreement between me and my insurance company and that I am financially responsible for all charges incurred as a result of my care, whether or not they are covered by my insurance. I acknowledge and understand that I will be required to pay my copays, coinsurance, and unmet deductibles on or before the day of service. (Ref: Financial Policy)

Authorization of Assignment of Insurance Benefits

_____ In consideration of medical services delivered by the office of James R Curtiss, MD, LLC, I authorize and agree to assign all medical benefits payable under an insurance carrier directly to James R. Curtiss, MD. The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Authorization to Release Medical Records

_____ I also hereby authorize the aforementioned to release records pertinent to my care to referring physicians, other health care facilities, and my insurance company.

Acknowledgement of Screening Colonoscopy Benefit

_____ I understand that colonoscopies are considered to be screening if, *and only if*, there is an **absence of** any gastrointestinal symptoms, including, but not limited to, constipation, diarrhea, or rectal bleeding. I understand that my insurance claims will be billed with the appropriate diagnostic codes, that my insurance company may not pay 100% of my colonoscopy, and that regular coinsurance and deductibles may apply. I also understand that, depending on the findings during the colonoscopy itself, some insurance companies may consider a screening colonoscopy to be diagnostic, and again, regular coinsurance and deductibles may apply.

I acknowledge that I have read and understand the information listed or referenced above.

Signature of Patient or Personal Representative

Date _____

Relationship to Patient (if Representative)