PRACTICE POLICIES / NOTICE OF PRIVACY PRACTICES / CONSENT

Thank you for choosing North Shore Primary Care. We are committed to providing high quality medical care. Our practice policies are as follows:

1. **Insurance**- Our office participates in many insurance plans. If you are not insured by a plan we do business with, payment in full is required at each visit. If you are insured by a plan we do business with but do not have an up to date insurance card, payment in full for each visit may be required until we can verify your coverage. **Knowing your insurance benefits is your responsibility**. Please contact your insurance company directly for any questions regarding your coverage. By signing this form, you authorize NSPC to release the necessary information in order to submit and process your insurance claims, and assign benefits directly to NSPC**. All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company**. Our staff will ask you to verify billing information at each and every visit. Current information is essential in order for us to obtain timely payment from your insurance company.

   I understand that some, and perhaps all, of the services I receive may not be covered by my insurance or not considered "reasonable or necessary" by Medicare or other insurers. I agree to pay for any services which have been determined by my insurance plan to be "non-covered." **Payment in full for these services is due at each visit.**

   I authorize NSPC to charge my credit card for copayments, balances due, and other associated charges related to my account. I understand that this authorization will remain in effect until I cancel it in writing. I agree to notify the business in writing of any changes in my account information. I certify that I am an authorized user of this card and that I will not dispute the payments with my credit card company provided the transactions correspond to the terms indicated in this form.

   I understand that if I am not insured, or am "self- pay" at the time of service, then payment in full is due at the time of service.

   We will submit your claims and help you get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply in a timely manner with their request. Please be aware that the balance of your claim is your responsibility, whether or not your insurance company pays your claim. If your insurance company does not pay your claim in 90 days, the balance may be billed to you. If your insurance changes, please notify us as soon as possible so we can make the appropriate changes to help you receive your maximum benefits.
2. **Nonpayment**- Please be aware that if a balance remains unpaid after 60 days, and you have made no attempt to make payment arrangements, we may refer your account to a collection agency, and you may be discharged from the practice. If this occurs, you will be notified by mail that you have 30 days to find alternative medical care. During the 30 day period, our physicians will be able to treat you on an emergency basis only. A $30.00 processing fee may be added to your account if it becomes necessary for us to refer your unpaid balance to an outside collection agency. If a balance greater than $100.00 remains on your account, payment of half of the remaining balance will be required before routine care can be continued with the practice.
3. **Missed Appointments**- You may be charged for a missed appointment if you do not notify us at least 24 hours prior to your scheduled appointment time.
4. **Returned Checks (NSF)** – You will be charged a $30.00 processing fee for any personal check returned for nonpayment.
5. **Communication** – We prefer to communicate by phone. We will text or call you to communicate information. We routinely leave messages on cell phones and answering machines. This includes communicating about test

results. Rarely, and for a variety of reasons, this may not occur. If you do not hear from our office about test results, please call us. We will often use pharmacy data to retrieve your prior prescriptions.

6. **Patients under the age of 18** – are legally entitled to confidentiality with regard to what is discussed during office visits. They are usually encouraged by our providers to discuss sensitive issues with close family members, but the providers need only disclose information if the patient is at risk for endangering him/herself or others.
7. **Routine/Preventive Care** – We believe that routine health care is extremely important. Well visits (yearly checkups) include a general physical, pap smear if needed, lab work, and age appropriate counseling. Most insurance plans will not cover both a well visit and a "sick" visit or a "follow-up" on the same day. If there are multiple issues to be discussed at your physical, you may be asked to schedule another visit to finish your physical, or you may be responsible for any balance nor covered by the insurance. Please note that not all insurance plans cover preventive care. Well care services must be coded as such, and altering coding in an attempt to obtain coverage is considered insurance fraud. Please do not ask our staff to do this. Routine care may include the recommendation for an immunization. Signature on this document indicates written consent for a vaccine once I have already verbally consented. **You may still owe charges for preventative care as some lab tests do not fall under the preventive care category by your insurance carrier.**

I have read and understand the payment policy and agree to abide by its guidelines.
I understand that by signing this agreement, I authorize the provision of clinical services.

Signature: _____ DOB: _____ Date: _____

NOTICE OF PRIVACY PRACTICES AND VOLUNTARY CONSENT

I hereby give my consent for North Shore Primary Care, SC to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO). NSPC, SC reserves the right to revise its Notice of Privacy Practices at any time. You have the right to request that NSPC, SC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, NSPC, SC may decline to provide treatment to me.

With this consent, North Shore Primary Care, S.C. may email or mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, laboratory results, and patient statements. The practice may also disclose health information to a family member or other person who is involved in my care. NSPC may use or disclose my medical information to bill and collect payment for services provided. The practice may contact me by either mail, email, or telephone at my cell, home or office for appointment reminders, payment matters, or any other matter related to health care services provided. We may leave messages. We may disclose medical information about you to a family member, other relative, close friend, or any other person if they are involved in your care or payments related to your care. If there is a family member, relative, or friend to whom you do not want us to disclose information about you, please notify us in writing.

I understand how the information may be used, the duties of NSPC, and my rights to privacy protection and access to my medical information.

Signature: _____ DOB: _____ Date: _____