Central Triad Retina

3333 Brookview Hills Blvd, Ste 107 | Winston-Salem, NC 27103
o 336.970.5900 f 336.842.3964
CentralTriadRetina.com

HIPAA Release

Sharing Information with Family and Friends

1. Please list the family members and/or other persons, if anyone, whom you may want us to inform about you general medical conditional and your diagnosis (including treatment, payment, and health care operations):

NAME:	RELATIONSHIP:	PHONE:
NAME:	RELATIONSHIP:	PHONE:
NAME:	RELATIONSHIP:	PHONE:

☐ Do not release my information to anyone.

2. Please list the family members and/or persons, if any, whom we may inform about your medical condition, **ONLY IN AN EMERGENCY:**

NAME:	RELATIONSHIP:	PHONE:
NAME:	RELATIONSHIP:	PHONE:
NAME:	RELATIONSHIP:	PHONE:

3. Please list those telephone number(s) where you want to receive calls:

PHONE:	PHONE:	PHONE:

4. Can confidential messages (for example: appointment information) be left on your voice mail/answering machine? ☐ Yes ☐ No

5. Can we send the following information electronically?

(Note: If other individuals have access to the contents of this electronic mail address, those individuals may have access to any information we send to that address. Central Triad Retina will not be responsible if such individuals access information sent to the electronic mail address you provide.)

Please select one from each line:

Information about your medical conditions: ☐ Yes ☐ No
Information about health related benefits or services: ☐ Yes ☐ No
Information about potential treatment option or alternatives: ☐ Yes ☐ No
Business matters including balances & insurance obligations: ☐ Yes ☐ No

While we may ask you from time-to-time if there have been any changes to this information, it is **your responsibility** to update this information as needed. These instructions will remain in effect until terminated by you in writing.

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Financial Agreements and Assignment of Benefits

Medicare: I request that payment of authorized Medicare benefits be made on my behalf to Central Triad Retina. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents, any information to determine these benefits payable for relatable services.

I understand my signature request that payment be made and authorizes the release of medical information as necessary to pay the claim. If other health insurance is indicated in Item 0 of the CMS-1500 form or elsewhere on another approved claim form, my signature authorizes releasing the information to the insurer or agency shown. Charge determination of the Medicare carrier as the full charge, and I am responsible for only the deductible, co-insurance, and non-covered insurance. Co-insurance and deductible are based upon the charge determination of the Medicare carrier.

MediGap: I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorized release of the information to insurer or agency shown. I request payment of authorized secondary insurance benefit be made on my behalf to Central Triad Retina, if possible, otherwise, to me.

Release of Information: Central Triad Retina may disclose all or any part of my medical records and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV to any person or corporation 1) which is or may be liable or under contract to Central Triad Retina for service rendered, and 2) any health care provider for continued patient care.

Central Triad Retina may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advance of medical science, medical education, medical research, for the collection of statistical data, or pursuant to State or Federal law, statute, or regulation. A copy of this authorization may be used in the place of the original.

Other Insurance: I understand that Central Triad Retina maintains a list of health care service plans with which is contract. The undersigned agrees that they are individually obligated to pay the full charge of all service rendered to me by Central Triad Retina if I belong to a plan that not appear on the above-mentioned list.

Non-Covered Services: I understand that Central Triad Retina contracts with health care service plans, such as HMO's, PPO's, and others which relate only to items and services that are covered by the health care service plans. Accordingly, the undersigned accepts full financial repsponsibilites for all items or services that are determined by the health care service plans not to be covered for whatever reason.

Examples of non-covered services include but are not limited to services not specified as being covered in the patients contract with a health care service plan or in the benefit summary the health care service plan furnished to the patient. The undersigned agrees to cooperate with Central Triad Retina to obtain necessary health care service plan authorizations, when needed.

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HIPAA Release

Financial Agreements and Assignment of Benefits (continued)

Financial Agreement: I agree that in return for the services provided to me by Central Triad Retina, I will pay my account at the time service is rendered or will make financial arrangements with the Billing Manager in advance of the appointment. If an account is sent to an attorney or collections agency, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not a jury in any court action.

I understand and agree that if my account is delinquent, I may be charged interest at a legal rate. Any benefit of any type under any policy of insurance insuring the patient, is hereby assigned to Central Triad Retina. If my insurance company or health plan designates co-payments and/or deductibles, I agree to pay them to Central Triad Retina at the time of service. However, it is understood that the undersigned and/or the patient are primarily responsible for payment of any remaining bill(s).

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HIPAA Release

Privacy Notices and Disclosures

This notice describes how information about you may be used and disclosed and how you can gain access to this information. We are glad to answer any questions you may have.

Central Triad Retina will make a photocopy of both your photo identification as well as your insurance card. These items are scanned into our secure medical record system. We use these items to identify you, to use as proof that you appeared here as a patient, and that we have your most current insurance information. If you do not have a photo identification, arrangements can be made at the time of check in.

We may use and disclose protected health information for treatment, payment, and healthcare operations. Examples of treatment disclosures include, but are not limited to, requested preschool or sport physicals, foster care homes, home health agencies, and/or referral to other providers for treatment. Payment examples include, but are not limited to, insurance companies for claims, including coordination of benefits with other insurers and/or collection agencies.

Healthcare operations include, but are not limited to, internal quality control and assurance and auditing of records.

Central Triad Retina is permitted or required to use or disclose protected health information without the individual's written consent or authorization in certain circumstances such as public health requirements or a court order. We will not make any other use or disclosure of protected health information without your express written consent. Such authorization may be revoked by you at any time. The request for revocation must be in writing:

Central Triad Retina reserves the right to change the terms of this notice and to make new notice provisions effective for all protected health information it maintains. We will provide each new patient with a copy of any revisions of its Notice of Information Practices at the time of their next visit, or at their last known address if there is a need to use or disclose any protected health information of the patient. Copies may also be obtained at any time at our office.

Central Triad Retina believes that any patient, guardian, or personal representative has the right to object to the use of their health information for directory purposes. Any patient, guardian, or personal representative has the right to inspect and obtain copies of their medical record. Any patient, guardian, or personal representative has the right to request amendments made to their medical records.

Any patient, guardian, or personal representative has the right to request a six (6) year accounting ofall disclosures made of their medical record. The history will be provided within sixty (60) days of the original request, and a reasonable charge maybe assessed for any copies after the first request made within a twelve (12) month period.

Any patient, guardian, or personal representative has the right to request restrictions as to how their health information may be used or disclosed to carry out treatment, payment, or healthcare operations. Central Triad Retina is not required to abide by the restrictions, but if Central Triad retina does agree it will abide by the restrictions.

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HIPAA Release

Privacy Notices and Disclosures (continued)

Any patient may file a complaint to Central Triad Retina and to the US Secretary of Health and Human Services if they believe their privacy rights have been violated.

To file a complaint with the practice, please contact the Privacy Officer in writing at 3333 Brookview Hills Blvd, Suite 107, Winston-Salem, NC 27103, by phone at 336.970.5900, or by fax at 336.842.3964.

All complaints will be addressed by the Privacy Officer by the guidelines defined in our company policy. It is our policy that absolutely no retaliatory-action be made against any patient who submits or conveys a complaint of suspected or actual non-compliance of privacy standards.

Central Triad Retina will abide by the terms of this notice currently in effect at the time of disclosure.

PATIENT OR GUARDIAN SIGNATURE DATE OF RECEIPT