

## FAMILY AND INSURANCE INFORMATION

Please complete the following form to aid us in updating your clinical records. All information is strictly confidential.

Parent/Guardian's Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Relation \_\_\_\_\_

Address \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_ Work Phone (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_ Cell Phone (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_

Parent/Guardian's Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Relation \_\_\_\_\_

Address \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_ Work Phone (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_ Cell Phone (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_

**Preferred Pharmacy** \_\_\_\_\_

**Email Address** \_\_\_\_\_

Children/Patients (Full Name)	DOB	Sex	Race	Ethnicity
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1	_____	_____	_____	_____
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2	_____	_____	_____	_____
---	-------	-------	-------	-------

3	_____	_____	_____	_____
---	-------	-------	-------	-------

4	_____	_____	_____	_____
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Child lives with:      Both Parents      Mother      Father      Other \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_

Relationship \_\_\_\_\_

### INSURANCE (Please present insurance card so copy may be obtained)

Insurance Company \_\_\_\_\_ ID# \_\_\_\_\_

Address of Company \_\_\_\_\_ Group# \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Subscriber's Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Relation \_\_\_\_\_

Address (if different than above) \_\_\_\_\_

Medicaid# (if applicable) \_\_\_\_\_

It is the member's responsibility to obtain referrals for specialty care in advance of services being rendered if the insurance is a managed care plan. I understand that I am responsible for services not authorized by my PCP. I hereby authorize payment directly to the provider of services and I understand that I am financially responsible for charges not covered by this authorization. I hereby authorize the release of any medical information necessary to process my insurance.

\*\*\*\*\*

It is the policy of this office that the person who accompanies the child for care will be responsible for payment of services rendered. Individuals other than parents/guardians bringing children to the office will be expected to present payment and/or insurance information. Payment required at the time of service-unless prior arrangements have been made.

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I UNDERSTAND AND GIVE AUTHORIZATION TO ALL ABOVE STATEMENTS.

I HAVE BEEN GIVEN A NOTICE OF PRIVACY PRACTICES OF NASSIM & ASSOCIATES, PSC.

**Signed** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_

May 2018

To our Parents:

As a medical practice our goal is to provide you with the best, most current medical care available in a positive and supportive environment. As a small business we must constantly strive to reduce and minimize our expenses and cost of doing business. Today insurance plans are becoming more complicated in how they determine what the medical practice can collect and what the patient actually owes. Insurance plans have numerous different co-payments, deductibles, and co-insurance that are often confusing to their clients and can even elude the smartest medical practice manager. What a patient actually owes once insurance pays its portion is a function of the individual's co-payment, deductible, maximum out-of-pocket expense and where the patient falls within this continuum.

In an effort to streamline this system and make it more cost effective for everybody we are giving you the opportunity to provide us with a credit card at the time of service. Nothing will be charged on your card without your permission. The only amount charged to your credit card will be the **PATIENT RESPONSIBILITY** portion as defined by your insurance.

As a small business operating on decreasing insurance reimbursements with rising costs of vaccines and other expenses, we must do everything possible to reduce the length of time that we extend credit to our patients.

This will be an advantage to you since you will no longer have to write out and mail us checks. It will be an advantage to us as well, since it will greatly decrease the number of statements that we have to generate and send out. The combination will benefit everybody in helping the cost of health care down.

Co-pays, deductibles, and co-insurance will continue to be due at the time of the visit. If you have any questions about this payment method do not hesitate to ask us.

Thank you for your cooperation and understanding.

Nassim McMonigle Mescia & Associates

THIS FORM MUST BE COMPLETED AND ON FILE

AUTHORIZATION TO CHARGE MY CREDIT CARD FOR THE "PATIENT RESPONSIBILITY" PORTION OF MY INSURANCE PAYMENT

I authorize All IN Pediatrics (Nassim & Associates, PSC) to charge my credit card with the balance due (patient responsibility) portion of my insurance (co-payment, deductible, co-insurance, past balances).

The family will be notified 24 hours prior to any transactions.

Phone# \_\_\_\_\_

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

\_\_\_\_\_ DOB \_\_\_\_\_

\_\_\_\_\_ DOB \_\_\_\_\_

\_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_

I AUTHORIZE ALL IN PEDIATRICS

To charge my credit card for my patient responsibility co-payment, deductible, co-insurance, or past balance.

CARD HOLDER NAME \_\_\_\_\_

CARD HOLDER SIGNATURE \_\_\_\_\_

CARD NUMBER \_\_\_\_\_ VISA \_\_\_\_\_ MC \_\_\_\_\_

CARD EXPIRATION DATE \_\_\_\_\_

TODAY'S DATE \_\_\_\_\_

I assign my insurance benefits to the provider listed above. I understand this form is effective until further notice unless I cancel the authorization through written notice to the health care provider.

\_\_\_\_\_

Signature Required

ALL IN Pediatrics  
2305 Green Valley Road New Albany, IN 47150  
1025 N Jim Day Road Salem, IN 47167  
Phone 812.949.0405  
Fax 812.949.0445

AUTHORIZATION FOR RELEASE OF PHI, PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize:

**PREVIOUS PHYSICIAN NAME/OFFICE:**

\_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

to disclose pertinent PHI including medical information, test results, x-rays, HIV/HTLV/AIDS test results, correspondence and surgical records about the child/children listed below to ALL IN Pediatrics

The PHI to be released (please specify):

- ☐ Entire medical record (INCLUDING psychiatric, mental health, alcohol and/or drug abuse and sexually transmitted disease information)
- ☐ Entire medical record (EXCLUDING psychiatric, mental health, alcohol and/or drug abuse and sexually transmitted disease information)
- ☐ Specific portions: (Please list specific portions such as, service, level of detail, origin of information, dates etc.)

Reason or need for release of records (please specify):

- ☐ Personal use
- ☐ Transfer of care
- ☐ Other (please specify)

\_\_\_\_\_

Patient Name(s):

_____	DOB: _____
_____	DOB: _____
_____	DOB: _____
_____	DOB: _____

I understand that I may revoke this authorization by submitting a revocation in writing to the Privacy Officer at ALL IN Pediatrics, at the above-named address except to the extent that ALL IN Pediatrics has acted in reliance upon this authorization.

This authorization expires 60 days from receipt unless otherwise indicated.

Signature of Parent/Guardian: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_

For office use only

Acct #: \_\_\_\_\_ Witnessed by: \_\_\_\_\_ Date: \_\_\_\_\_

**NASSIM AND ASSOCIATES, PSC**

**Notice of Privacy Practices**

NASSIM AND ASSOCIATES, PSC NOTICE OF PRIVACY PRACTICES  
As Required by the Privacy Regulations Promulgated Pursuant to the Health Insurance  
Portability and Accountability Act of 1996(HIPAA)

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND  
HOW YOU CAN GET ACCESS TO YOUR IDENTIFIABLE HEALTH INFORMATION.**

**PLEASE REVIEW THIS NOTICE CAREFULLY.**

**A. OUR COMMITMENT TO YOUR PRIVACY**

Our practice is dedicated to maintaining the privacy of your identifiable health information. In conducting your business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and privacy practices concerning your identifiable health information. By law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

To summarize, this notice provides you with the following important information:

- ☐ How we may use and disclose your identifiable health information
- ☐ Your privacy rights in your identifiable health information
- ☐ Our obligations concerning the use and disclosure of your identifiable health information.

The terms of this notice apply to all records containing your identifiable health information that are created or retained by our practice. We reserve the right to revise or amend our notice of privacy practices. Any revision or amendment to this notice will be effective for all of your records our practice has created or maintained in the past, and for any of your records we may create or maintain in the future. Our practice will post a copy of our current notice in our offices in a prominent location, and you may request a copy of our most current notice during any office visit.

**B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:**

OFFICE MANAGER, NASSIM AND ASSOCIATES, PSC  
(812) 949-0405

**C. WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION IN THE FOLLOWING WAYS**

The following categories describe the different ways in which we may use and disclose identifiable health information.

1. **Treatment.** Our practice may use your identifiable health information to treat you. For example, we may ask you to undergo laboratory test (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We use your identifiable health information in order to write a prescription for you, or we might disclose your identifiable health information to a pharmacy when we call and order a prescription for you. Many of the people who work for our practice - including doctors and nurses - may use or disclose your identifiable health information in order to treat you or to assist others in your treatment. Additionally, we may disclose your identifiable health information to others who may assist in your care, such as your spouse, children or parents.
2. **Payment.** Our practice may use and disclose your identifiable health information in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your identifiable health information to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your identifiable health information to bill you directly for services and items.
3. **Health Care Operations.** Our practice may use and disclose your identifiable health information to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your

**Effective Date of this Notice: 01/01/03**

health information to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice.

4. **Appointment Reminders.** Our practice may use and disclose your identifiable health information to contact you and remind you of an appointment.
5. **Treatment Options.** Our practice may use and disclose your identifiable health information to inform you of potential treatment options or alternatives.
6. **Health-Related Benefits and Services.** Our practice may use and disclose your identifiable health information to inform you of health-related benefits or services that may be of interest to you.
7. **Release of Information to Family/Friends.** Our practice may release your identifiable health information to a friend or family member that is helping you pay for your health care, or who assists in taking care of you.
8. **Disclosures Required By Law.** Our practice will use and disclose your identifiable health information when we are required to do so by federal, state or local law.

#### **D. USE AND DISCLOSURE OF YOUR IDENTIFIABLE HEALTH INFORMATION IN CERTAIN SPECIAL CIRCUMSTANCES**

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. **Public Health Risks.** Our practice may disclose your identifiable health information to public health authorities that are authorized by law to collect information for the purpose of :
  - ☐ Maintaining vital records, such as births and deaths
  - ☐ Reporting child abuse or neglect
  - ☐ Preventing or controlling disease, injury or disability
  - ☐ Notifying a person regarding a potential risk for spreading or contracting a disease or condition
  - ☐ Reporting reactions to drugs or problems with products or devices
  - ☐ Notifying individuals if a product or device they may be using has been recalled
  - ☐ Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of a patient(including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
  - ☐ Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.
2. **Health Oversight Activities.** Our practice may disclose your identifiable health information to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions, civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.
3. **Lawsuits and Similar Proceedings.** Our practice may use and disclose your identifiable health information in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your identifiable health information in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.
4. **Law Enforcement.** We may release identifiable health information if asked to do so by a law enforcement official:
  - ☐ Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
  - ☐ Concerning a death we believe might have resulted from criminal conduct
  - ☐ Regarding criminal conduct at our offices
  - ☐ In response to a warrant, summons, court order, subpoena or similar legal process
  - ☐ To identify/locate a suspect, material witness, fugitive or missing person
  - ☐ In an emergency to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

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5. **Deceased Patients.** Our practice may release identifiable health information to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.
6. **Organ and Tissue Donation.** Our practice may release your identifiable health information to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.
7. **Research.** Our practice may use and disclose your identifiable health information for research purposes in certain limited circumstances. We will obtain your written authorization to use your identifiable health information for research purposes except when: (a) our use or disclosure was approved by an Institutional Review Board or a privacy Board; (b) we obtain the oral or written agreement of a researcher that (i) the information being sought is necessary for the research study; (ii) the use or disclosure of your identifiable health information is solely to prepare a research protocol or for similar preparatory research, and (iii) the researcher will not remove any of your identifiable health information from our premises; or (c) the identifiable health information sought by the researcher only relates to decedents and the researcher agrees either orally or in writing that the use or disclosure is necessary for the research and if we request it, to provide us with proof of death prior to access to the identifiable health information of the decedents.
8. **Serious Threats to Health or Safety.** Our practice may use and disclose your identifiable health information when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
9. **Military.** Our practice may disclose your identifiable health information if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate military command authorities.
10. **National Security.** Our practice may disclose your identifiable health information to federal officials for intelligence and national security activities authorized by law. We also may disclose your identifiable health information to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.
11. **Inmates.** Our practice may disclose your identifiable health information to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary : (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.
12. **Workers' Compensation.** Our practice may release your identifiable health information for workers' compensation and similar programs.

#### **E. YOUR RIGHTS REGARDING YOUR IDENTIFIABLE HEALTH INFORMATION**

You have the following rights regarding the identifiable health information that we maintain about you:

1. **Confidential Communications.** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to the Office Manager of Nassim and Associates, PSC, 2305 Green Valley Road, New Albany, IN 47150, specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.
2. **Requesting Restrictions.** You have the right to request a restriction in our use or disclosure of your identifiable health information for treatment, payment or health care operations. Additionally, you have the right to request that we limit our disclosure of your identifiable health information to individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when disclosure of your identifiable health information, you must make your request in writing to the Office Manager of Nassim and Associates, PSC, 2305 Green Valley Road, New Albany, IN 47150. Your request must describe in a clear and concise fashion: (a) the information you wish restricted; (b) whether you are requesting to limit our practice's use, disclosure or both; and (c) to whom you want the limits to apply.

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3. **Inspection and Copies.** You have the right to inspect and obtain a copy of the identifiable health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the Office Manager of Nassim and Associates, PSC, 2305 Green Valley Road, New Albany, IN 47150 in order to inspect and/or obtain a copy of your identifiable health information. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.
4. **Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the Office Manager, Nassim and Associates, PSC at 2305 Green Valley Road, New Albany, IN 47150. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is: (a) accurate and complete; (b) not part of the identifiable health information kept by or for the practice; (c) not part of the identifiable health information which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.
5. **Accounting of Disclosures.** All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain disclosures our practice has made of your identifiable health information. In order to obtain an accounting of disclosures, you must submit your request in writing to the Office Manager, Nassim and Associates, PSC, 2305 Green Valley Road, New Albany, IN 47150. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.
6. **Right to a Paper Copy of This Notice.** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact the Office Manager, Nassim and Associates, PSC, (812) 949-0405.
7. **Right to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the Office Manager, Nassim and Associates, PSC, 2305 Green Valley Road, New Albany, IN 47150. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
8. **Right to Provide an Authorization for Other Uses and Disclosures.** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your identifiable health information may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your identifiable health information for the reasons described in the authorization. Please note, we are required to retain records of your care.

Revised 01/01/2014

**Consent to Wireless Telephone Calls:** If at any time I provide a wireless telephone number at which I may be contacted, I consent to receive calls or text messages, including but not restricted to communications regarding billing and payment for items and services, unless I notify the office to the contrary in writing. In this section, calls and text messages include but are not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text messaging or by any other form of electronic communication from the office, attorneys or its agents including collection agencies.

**Consent to email usage:** If at any time I provide my email address at which I may be contacted, unless I notify the office to the contrary in writing, I consent to receiving communications regarding billing and payment for items and services at that email address from the office, attorneys, or its agents including collection agencies.

Revised 12/23/2014

Again, if you have any questions regarding this notice or our health information privacy policies; please contact the Office Manager, Nassim and Associates, PSC at (812) 949-0405.

## ALL IN Pediatrics

### Medical Consent Authorization and Consent Form

This document is for situations where minors are unaccompanied by either the parent or legal guardian. This “Medical Consent Authorization and Consent Form” gives authority for a designated adult, named by the parent or legal guardian to bring the minor in for appointments, receive medical information, pick up prescriptions, and authorize immunizations.

Patient(s) Name/DOB: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Below please list 3 designated adults and their relation to the patient that you give permission to bring to appointments, receive medical information, pick up prescriptions, and authorize immunizations.

Name of designated adult/relation:

\_\_\_\_\_

Name of designated adult/relation:

\_\_\_\_\_

Name of designated adult/relation:

\_\_\_\_\_

Parent Name: \_\_\_\_\_

\_\_\_\_\_

Parent Signature and Date

**NASSIM AND ASSOCIATES, PSC**

**Patient Consent for Use and Disclosure of Protected Health Information**

**With my consent, Nassim and Associates, PSC may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Nassim and Associates, PSC Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review your Notice of Privacy Practices prior to signing this consent. Nassim and Associates reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices any be obtained by forwarding a written request to our Privacy Officer at 2305 Green Valley Road, New Albany, IN. 47150.**

With my consent, Nassim and Associates, PSC may call my home or office and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO such as appointment reminders, insurance items and any call pertaining to your clinical care, including laboratory results among others.

**“Consent to Wireless Telephone calls: If at any time I provide a wireless telephone number at which I may be contacted, I consent to receive calls or text message, including but not restricted to communications regarding billing and payment, appointments, lab results, etc. for items and services, unless I notify Nassim McMonigle & Mescia to the contrary in writing. In this section, calls and text messages include but are not restricted to pre-recorded messages, artificial voice message, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text messaging or by any other form of electronic communication from Nassim McMonigle & Mescia.”**

With my consent, Nassim and Associates, PSC may mail to my ☐ home or ☐ office any items that assist the practice in carrying out TPO such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, Nassim and Associates, PSC may e-mail to my ☐ home or ☐ office any items that assist the practice in carrying out TPO such as appointment reminder cards and patient statements.

**“Consent to email usage: If at any time I provide my email address at which I may be contacted, unless I notify Nassim McMonigle & Mescia to the contrary in writing, I consent to receiving communications regarding billing and payment, appointments, lab results, etc. for items and services at that email address from Nassim McMonigle Mescia.”**

I have the right to request that Nassim and Associates, PSC restrict how Nassim and Associates, PSC uses or discloses my PHI to carry out TPO. However, Nassim and Associates, PSC is not required to agree to my requested restrictions, but if Nassim and Associates, PSC does, they are bound by our agreement.

By signing this form, I am consenting to Nassim and Associates, PSC’s use and disclosure of my PHI to carry out TPO. This consent may be revoked in writing except to the extent that Nassim and Associates, PSC has already made disclosures in reliance upon my prior consent. If I decline to sign this consent, Nassim and Associates, PSC may decline to provide treatment to my child/children.

\_\_\_\_\_  
Signature of Parent/Legal Guardian                      Date

\_\_\_\_\_  
Print Name of Parent/Legal Guardian

\_\_\_\_\_  
Patient’s Name                      DOB                      Patient’s Name                      DOB

\_\_\_\_\_  
Patient’s Name                      DOB                      Patient’s Name                      DOB

\*\*\*\*\*

List up to 3 names that you give consent to receive medical information and bring your child to appointments:

\_\_\_\_\_

**NASSIM AND ASSOCIATES, PSC.**  
**FINANCIAL POLICIES AND PROCEDURES**

Thank you for choosing us as your health care provider. We are committed to providing you with the best possible care and to your treatment being successful. Your clear understanding of our financial policy is important to our professional relationship. Please understand that payment of your bill is considered part of your treatment. We accept CASH, CHECK, MONEY ORDER, VISA, and MASTERCARD.

**INSURANCE: \_\_\_\_\_ (Initial)**

Our practice is committed to providing the best treatment for our patients. We must emphasize that as Medical Care providers, our relationship is with our patient, not with your insurance company. We cannot accept the responsibility of negotiating the claims with insurance companies or any other persons. While filing of insurance claims is a "courtesy" that we extend to our patients, all charges are your responsibility from the date of the services rendered.

Your insurance is a contract between you and the insurance company. It is very important that you understand the provisions of your policy. We cannot guarantee payment of claims. If your insurance company pays only a portion of the bill or rejects your claims, any contact or explanation should be made to you, the policyholder. Reduction or rejection of your claim by your insurance company does not relieve you of your financial obligation.

Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. Some of the services may be considered "non-covered" services and not medically necessary under some medical insurance programs. Please remember that professional services are rendered and charged to the patient, not the insurance company.

We charge what is usual and customary for our area. The patient is responsible for payment in full within a reasonable time-regardless of the status of the claim or any insurance company's arbitrary determination of usual customary rates. Our fees are considered to fall within the acceptable range of most companies and therefore are covered up to maximum allowance determined by each carrier.

The physician is required to report services using a variety of diagnostic ICD and CPT management and treatment codes. Different insurance companies and plans may initiate co-pay or additional charges to your account based on the illness or preventive codes used.

If you have a managed care medical insurance with which we participate, your payment of deductibles, non-covered services and co-payments are due when services are rendered. If we do not participate with your insurance company or if you do not have health insurance coverage, payment in full for services is due at the time of services are rendered.

Although an insurance claim is filed, you will receive a monthly statement if your account has a patient balance due. This office cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim. The patient is responsible for payment.

We realize that temporary financial problems may affect timely payment on your account. We encourage you to contact our billing manager for assistance in the management of your account. In the event that your account becomes delinquent and you have not responded to our collection efforts, your account may be turned over to an outside source of collecting the balance due on the account at which time you will be asked to seek care elsewhere. You are responsible for all charges including any agency fees and interest assessed to the account.

If you do not provide us with the complete and accurate insurance information for each visit (within the timely filing limits set by your insurance company(ies)), you will be held responsible for any outstanding balances.

**RETURNED CHECKS: \_\_\_\_\_ (Initial)**

Any returned checks are subject to a \$25.00 service fee. Any returned check must be resolved before any future appointments can be arranged.

**BANKRUPTCY: \_\_\_\_\_ (Initial)**

It is policy of this office that when any bankruptcy case notices are received which list the debtor as the guarantor of any active patient account, appointments will be allowed on a CASH BASIS ONLY. All charges incurred must be paid at the time services are rendered regardless of insurance status. If a payment is then received from your insurance company, a refund will be issued.

*I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.*

---

Patient or responsible party

---

Date

**NASSIM AND ASSOCIATES, PSC.**  
**FINANCIAL POLICIES AND PROCEDURES (cont'd)**

**FORMS: \_\_\_\_\_ (Initial)**

Please bring any form (school, sports, daycare, etc) that requires completion with you for your child's appointment. It will be completed "no charge" as part of the office visit. There will be a \$5.00 charge to complete any other form not presented at your appointment payable in advance. This fee will not be billed to your insurance company. FMLA forms will be completed; however there will be a \$25.00 fee payable in advance and will not be billed to your insurance.

**MEDICAL RECORDS: \_\_\_\_\_ (Initial)**

In accordance with the Indiana State Statute IC 16-39-9-4, Nassim & Associates will provide copies of records for the following fees:

- Twenty dollar (\$20.00) labor fee which includes the first 10 pages
- Fifty cents (\$.50) per page for pages eleven (11) through fifty (50)
- Twenty five cents (\$.25) per page for pages fifty one (51) and higher
- Actual mailing costs
- Ten dollar (\$10.00) rush fee if records are to be provided within two (2 ) business days
- Twenty dollar (\$20.00)certifying fee if requested

(One copy of the patient(s) medical records will be provided upon request, at no charge, released to parent or other physician's office)

**MINOR AGE PATIENTS: \_\_\_\_\_ (Initial)**

- a. Responsible Party – For new patients, the parent or legal guardian must be present. Appointments and procedures cannot be scheduled without a parent or legal guardian present.
- b. Charges – Charges for services rendered to minor children are the responsibility of the parent who seeks treatment for the child and are due at the time of service.
- c. Minor Children of Divorced Parents – Payments, co-pays, co-insurance and deductibles are due at the time of service from the parent who seeks treatment for the child regardless of any court-ordered responsibility for medical costs. If the parents have agreed to share health care expenses, the parent who seeks treatment is solely responsible for collecting reimbursement from the other parent. This practice will not get involved in custodial, separation or financial disputes involving or relating to divorced parents for a minor child to whom we provide services.
- d. Non-custodial Parent – The non-custodial parent must be listed on the HIPAA Form

**PREGNANCY: \_\_\_\_\_ (Initial)**

It is the policy of this office that if we have a patient who becomes pregnant or marries, we ask that they seek the care of an adult PCP. As a pediatrician, we treat only the child not the parent and the child.

**MEDICAID AND PRIVATE INSURANCES: \_\_\_\_\_ (Initial)**

If you are covered by one of the above, or any other government sponsored program, you must present your current insurance card prior to services being rendered. If your card is not available, we will be happy to reschedule your appointment.

**AUTOMOBILE ACCIDENTS: \_\_\_\_\_ (Initial)**

If you are covered by the above, we do not file on these services and payment in full is due at time of service, although we will provide you with any information that you may need to file for these services on your own.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

*I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.*

\_\_\_\_\_  
Patient or responsible party

\_\_\_\_\_  
Date



## Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

**Please review it carefully.**

### Your Rights

**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.

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#### Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

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#### Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

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#### Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
  - We will say “yes” to all reasonable requests.
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## Your Rights *continued*

### Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
  - We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
  - We will say “yes” unless a law requires us to share that information.

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### Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

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### Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

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### Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

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### File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **[www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/)**.
- We will not retaliate against you for filing a complaint.

## Your Choices

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

**In these cases, you have both the right and choice to tell us to:**

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory
- Contact you for fundraising efforts

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

**In these cases we *never* share your information unless you give us written permission:**

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

**In the case of fundraising:**

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

## Our Uses and Disclosures

**How do we typically use or share your health information?** We typically use or share your health information in the following ways.

<b>Treat you</b>	<ul style="list-style-type: none"><li>• We can use your health information and share it with other professionals who are treating you.</li></ul>	<b>Example:</b> A doctor treating you for an injury asks another doctor about your overall health condition.
<b>Run our organization</b>	<ul style="list-style-type: none"><li>• We can use and share your health information to run our practice, improve your care, and contact you when necessary.</li></ul>	<b>Example:</b> We use health information about you to manage your treatment and services.
<b>Bill for your services</b>	<ul style="list-style-type: none"><li>• We can use and share your health information to bill and get payment from health plans or other entities.</li></ul>	<b>Example:</b> We give information about you to your health insurance plan so it will pay for your services.

*continued on next page*

**How else can we use or share your health information?** We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html).

<b>Help with public health and safety issues</b>	<ul style="list-style-type: none"><li>• We can share health information about you for certain situations such as:<ul style="list-style-type: none"><li>• Preventing disease</li><li>• Helping with product recalls</li><li>• Reporting adverse reactions to medications</li><li>• Reporting suspected abuse, neglect, or domestic violence</li><li>• Preventing or reducing a serious threat to anyone's health or safety</li></ul></li></ul>
<b>Do research</b>	<ul style="list-style-type: none"><li>• We can use or share your information for health research.</li></ul>
<b>Comply with the law</b>	<ul style="list-style-type: none"><li>• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.</li></ul>
<b>Respond to organ and tissue donation requests</b>	<ul style="list-style-type: none"><li>• We can share health information about you with organ procurement organizations.</li></ul>
<b>Work with a medical examiner or funeral director</b>	<ul style="list-style-type: none"><li>• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.</li></ul>
<b>Address workers' compensation, law enforcement, and other government requests</b>	<ul style="list-style-type: none"><li>• We can use or share health information about you:<ul style="list-style-type: none"><li>• For workers' compensation claims</li><li>• For law enforcement purposes or with a law enforcement official</li><li>• With health oversight agencies for activities authorized by law</li><li>• For special government functions such as military, national security, and presidential protective services</li></ul></li></ul>
<b>Respond to lawsuits and legal actions</b>	<ul style="list-style-type: none"><li>• We can share health information about you in response to a court or administrative order, or in response to a subpoena.</li></ul>

## Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

### Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

**This Notice of Privacy Practices applies to the following organizations.**