ACKNOWLEDGEMENT OF RECEIPT AND ACCEPTANCE OF:
Notice of Privacy Practices Informed Consent
Practice Financial Policies
ADVANCED SPECIALTY CARE

Privacy Officer: Jennifer Retter, Privacy Officer (203) 830-4700 ext. 8265

I hereby acknowledge that I was given the opportunity to review this medical practice's **Notice Of Privacy Practices (HIPAA),** and that I have the right to ask for a paper copy of the Notice to take with me. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment. Due to HIPAA laws, we are unable to share your medical information with anyone unless you authorize to do so.
I authorize the person(s) listed below to discuss my medical information:

_____ _____
Name & phone number **Relationship to Patient**

_____ _____
Name & phone number **Relationship to Patient**

I authorize Advanced Specialty Care staff to leave medical information, including test results, on the following voicemail/answering machines: ☐ **Home Phone** ☐ **Work Phone** ☐ **Cell Phone**

☐ I hereby authorize Advanced Specialty Care to correspond with me/authorized persons via email regarding my medical care.

Release of Records to Electronic Portal: I understand that my signature on this form authorizes Advanced Specialty Care to send my personal medical records to my personal Electronic portal account when verbally requested. I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this form, I am authorizing such information to be disclosed. This authorization is effective indefinitely unless revoked in writing. I would like the following health information to be sent to my portal account:
☐ All records Other:_____

Please note that ASC employees may discuss payment issues with family members or other personal representatives, including the subscriber of my insurance plan, unless I request special privacy protections. My signature on this form authorizes such financial discussion.
Please initial each statement on line provided:
___ Under certain circumstances, this office may need to request lab reports, radiology reports, other diagnostic test results, and/or medication history from outside facilities in order to provide treatment. At times these facilities may require an authorization to release such records. My signature authorizes the release of these records.

___ I understand that no procedure provided by this facility is completely without risk and I authorize the care and treatment provided to me under the general or specific directions of my physician or my physician assistant.

___ I understand that I will be charged a $25-$125 **NO-SHOW** fee if I do not show up at my scheduled appointment. In order to avoid the **NO-SHOW** fee an appointment needs to be cancelled 24 hours prior.

___ I understand any office procedures/tests done today may fall under a different insurance benefits classification, therefore may require additional out of pocket cost beyond the office visit fee.

If this office does not have a contract with my insurance company, payment must be made at the time of visit unless prior arrangements have been made with the office manager. For patients with coverage that we participate with we will file your insurance claims to your primary carrier for all services and procedures we provide. It is your responsibility to secure all referrals and authorizations required by your health plan and to be aware of its coverage and benefits. All charges are your responsibility from the date the services are rendered. I understand that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. If payment is not received in a timely manner, my account will be turned over to a collection agency. I agree to notify the office of Advanced Specialty Care of any changes to my insurance coverage so that filing my claim is expedited. I understand that any unpaid balances 120 days or older will incur $15 per month late fee.

_____ _____
Patient Signature (Parent/Guardian sign if Patient a Minor) **Relationship to Patient**

_____ _____/_____/_____
Please Print Name **Date**

_____ _____/_____/_____
Patients Name (if Minor) **Patient's date of birth**