



HIPAA – Privacy Policy

It is the policy of our practice that all physicians and staff members preserve the integrity and the confidentiality of protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our entire practice have the necessary medical and PHI to provide our patients the highest quality medical care possible patients should not be afraid to provide information to our practice, physicians, staff members for purposes of treatment, payment, and healthcare procedures. Our HIPPA policy in its entirety can be obtained through our office at any time. Let us know if you would like to receive a copy prior to signing this consent.

Office Policy on managed Care Insurers

We are pleased to meet the needs of our patients and referring physicians by enrolling with various managed care insurance programs. While we are able to provide you with this service, it is extremely difficult to keep track of all the individual requirements of each plan. Even with the same insurance company, plans often may differ. Providing quality medical care for our patients is our primary concern, and we are more than willing to provide that care based on your insurance contract guidelines. We request at each visit that you advise us of your guideline requirements.

Unfortunately, if you do not inform us of any special requirements in your contract and we subsequently provide services, or order services such as label work or hospitalization that are not covered, we or the medical facility will have no choice but to bill you directly for all said charges. All fees submitted and denied by your insurance carrier will become your responsibility.

Our practice will file insurance claims as a courtesy for you, however, office visit co-pays and deductibles are payable on the day of your visit. Remember that you are responsible for all fees, regardless of your insurance coverage. Some insurance plans require prior authorization and/or referral documentation. This is your responsibility. If we do not receive the authorization and/or referral documentation in advance, payment is due at the time of service.

With your cooperation, you should be able to receive all benefits offered by your insurance plan, and we will be able to concentrate on caring for your medical needs.

Authorization

Please initial and sign below:

_____ I understand HIPAA and its policies.

_____ I have read and understand the office policy stated above and agree to accept responsibility as described.

_____ I authorize the release of medical information necessary to process a claim, to health care professionals requesting consultation, and third party payers responsible for payment of medical and surgical benefits to Johns Creek Dermatology and Family Medicine.

Patient Name: _____ **Date:** _____

Signature of Patient or Personal

Representative: _____ **Date:** _____

If Personal Representative, give relationship to patient: _____