Dear Patient,

We have a signed consent form on file that one of your parents has signed giving us consent to treat you and, if covered, to bill the Insurance Company.

Now that you are 18 years old we need a signed copy from you on file. Attached is a copy of the HIPAA form.

Please sign the attached HIPAA privacy form. In addition, there is a Personal Health Information Disclosure Agreement enclosed. If you would like to grant us permission to share your personal health information with a personal representative (including parent(s)), please sign the form. You may either bring these forms into our office, fax to our office at 270-846-4828 or e-mail these forms to billing@bgimp.com.

Should you or your parents have any questions in regards to this, please contact our office at 270-846-4800 and speak with a staff member.

Thank You,

Bowling Green Internal Medicine & Pediatric Associates

BOWLING GREEN INTERNAL MEDICINE AND PEDIATRICS ASSOCIATES
TREATMENT AUTHORIZATIONS AND FINANCIAL POLICIES

FINANCIAL POLICY FOR PATIENTS

Effective July 10, 2000 our office has established specific financial policies in reference to services rendered by Bowling Green Internal Medicine and Pediatrics, Associates. Our office *does not accept walk in appointments*. Appointment times over *20 minutes* late will have to be rescheduled for another date and time. The financial policies are as follows:

MEDICARE PATIENTS

On January 1st of each calendar year Medicare requires that a $150.00 deductible be satisfied prior to benefits being paid at 80% of the reasonable and customary amount. If you have not met your deductible prior to your office visit you will be responsible for your charges until your deductible is met. Once the deductible is satisfied you will be responsible for 20% of your charges. The only exception to this is a secondary supplemental plan that would cover the 20% of your charges. Please present all insurance cards to the front office upon your initial visit so this can be identified. If our office is aware that certain services are considered non-covered by Medicare, you will be asked to sign an Advance Beneficiary Notice that we informed you of any non covered service and your financial responsibility.

MEDICAID PATIENTS

You must have your Medicaid card available upon each visit to the office so that we can verify eligibility for that time period. If you do not have your Medicaid card available your appointment will have to be rescheduled for another date and time.

COMMERCIAL INSURANCE PATIENTS

Upon your initial visit to our office please present your insurance card. Our office will call your insurance to verify coverage and eligibility. You will be responsible for any applicable deductibles, co-pays and non-covered services that are required to be paid at the time of service. Insurance claims are billed to your insurance company as a courtesy; however, it is your responsibility to understand your insurance benefits as well as how your insurance processes and pays your claims.

SELF-PAY PATIENTS

Our office does not accept new self-pay patients unless approved by the physician and prior arrangements have been made. Payment will be required at the point of service.

WORKMAN'S COMPENSATION

Any patient being seen for a work related injury must have prior written approval from the workman's compensation carrier prior to being seen. Our office must be able to verify the reason for the visits as well as coverage for the date of service. The information should include the insurance company name, address, phone number, adjuster's name, injury date and workman's claim number. We cannot schedule the patient without this information. Failure to present this information on the day of the visit will result in rescheduling the visit for another date and time.

THIRD PARTY LIABLITY CLAIMS

Third party liability claims will be considered on a case-by-case basis. Prior to the visit in our office we will require all necessary billing information in writing. This information will include the names of all involved parties; complete insurance information, adjusters name and claim number if applicable. If you have attorney representation this information must also be provided.

REFERRALS

Please be aware of our office policy in reference to referrals. If your insurance company requires a referral when seeing another physician or specialist, please allow us 7 days notice to prepare your referral form for a non-emergency visit. If the 7 day notice is not received or another physician's office calls the day of the appointment, in a non emergency situation, the referral will be denied and you will be responsible for the visit. All non-emergent referrals will be done on the Monday prior to your visit with the other physician or specialist. All emergency referrals will be handled on a case-by-case basis. Please notify the office as soon as possible in an emergency situation. As a courtesy, we would like to inform you that various insurance companies will not allow us to do a back dated referral. It is very important that you keep us informed when a referral is needed for any reason. It is the responsibility of the patient, or insured if a minor child is involved, to inform our office if a referral is needed due to the various numbers of insurance companies and policies that have different levels of benefits.

This financial policy will be strictly adhered to with the only exceptions being when prior arrangements have been made. Please direct any billing questions to the billing supervisor or the office manager.

_____ _____

Signature Responsible Party or Parent of Minor Child Signature Date

AUTHORIZATION FOR MEDICAL/SURGICAL TREATMENT

I hereby authorize S.Augusta Mayfield, MD, and/or Paul Kniery, MD, and/or Kelly Kries, MD, and/or Caroline Garrett, MD, and/or Ashley Parrigin, APRN, and/or Emily Cope, APRN to administer such anesthetics and/or Medications and to perform such operations and/or procedures, and to admit to such hospital as may be deemed advisable in diagnosis and treatment of this patient. I have custody and/or responsibility for this patient and I have read the above and understand fully the contents thereof.

_____ _____ _____

Signed Relationship to Patient Date

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize payment of insurance benefits to be made directly to S.Augusta Mayfield, MD, and/or Paul Kniery, MD, and/or Kelly Kries, MD, and /or Caroline Garrett, MD, and/or Ashley Parrigin, APRN, and/or Emily Cope, APRN for services rendered. I also herby authorize S.Augusta Mayfield, MD, and/or Paul Kniery, MD, and/or Kelly Kries, MD, and /or Caroline Garrett, MD, and/or Ashley Parrigin, APRN, and/or Emily Cope, APRN to release records pertinent to my care to referring physicians, and other healthcare facilities and my insurance company.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

_____ _____ _____

Signed Relationship to Patient Date

HIPAA

By signing this form, you consent to our use and disclose of protected health information about your for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act (HIPAA). I understand that the HIPAA policy is posted in both lobbies, and a copy will be made available to me upon my request.

Signed _____ Date_____

BOWLING GREEN INTERNAL MEDICINE AND PEDIATRIC ASSOCIATES

PATIENT HIPAA CONSENT FORM

Our Notice of privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains a Patient Rights section describing your rights under law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

Your have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do we shall honor that agreement.

By signing the attached form, you consent to our use and disclosure of protected health information about your for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on our prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

1. Protected health information may be disclosed or used for treatment, payment or healthcare operations.
2. The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
3. The Practice reserved the right to change the Notice of Privacy Policies.
4. The patient has the right to restrict the use of their information but the Practice does not have to agree to those restrictions.
5. The patient may revoke this in writing at any time and all future disclosures will then cease.
6. The Practice may condition treatment upon the execution of this consent.

Bowling Green Internal Medicine & Pediatric Associates
1701 Ashley Circle Suite 200
Bowling Green, KY 42104
Phone: (270) 846-4800 Fax: (270) 846-4828

Notice of Privacy Practices and Patient Consent
For Use and Disclosure of Protected Health Information

PATIENT NAME **DATE**

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that Bowling Green Internal Medicine and Pediatric Associates may use or disclose my protected health information for treatment, payment or health care operations—which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Bowling Green Internal Medicine and Pediatric Associates has a detailed document called the ***'Notice of Privacy Practices'***. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the *'Notice'* before signing this agreement. If I ask, Bowling Green Internal Medicine and Pediatric Associates will provide me with the most current *Notice of Privacy Practices*.

My signature below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices*. My signature means that I agree to allow Bowling Green Internal Medicine and Pediatric Associates to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Bowling Green Internal Medicine and Pediatric Associates has taken action relying on this consent.

SIGNATURE (Patient or Legal Custodian/Authorized Representative) **DATE**

Relationship to Patient if signed by another party **DATE**

You may obtain a copy of our *Notice of Privacy Practices*, including any revisions of our *'Notice'* at any time by contacting: BG Internal Medicine & Pediatric Associates, 1701 Ashley Circle Suite 200, Bowling Green, KY 42104 Phone (270) 846-4800 Fax (270) 846-4828.

Personal Health Information Disclosure Agreement for Bowling Green Internal Medicine & Pediatric Associates

I, _____, do hereby grant permission for Bowling Green Internal Medicine & Pediatric Associates, to disclose my personal health information to the following personal representatives(s): (spouse, sibling, parent, child, friend, etc.)

_____

_____

_____

_____

Information to be disclosed (please check):

- ❑ **Appointment dates and times** ❑ **Treatment plans and referrals**
- ❑ **Financial and billing information**
- ❑ **Any other pertinent health information related to treatment at this office.**

❑ ❑ **None of the above**

I understand that this permission will remain in effect unless a written cancellation has been provided to Bowling Green Internal Medicine & Pediatric Associates.

_____ _____

Patient Signature **Date**

_____

Patient's Date of Birth

_____ _____

Witness Signature **Date**