NOMS HEALTHCARE

Patient:
Patient Date of Birth:

1.03 HIPAA Patient Acknowledgment

I hereby permit Northern Ohio Medical Specialists to release any information acquired throughout the course of my examination and treatment as needed to process any claims on my behalf.

HIPAA Notice of Patient Privacy Practices

I hereby agree, in accordance with HIPAA regulations, that I have been advised of NOMS Healthcare privacy policy. I may request a paper copy of the NOMS Healthcare Notice of Privacy Practices at any time. I permit NOMS to release or obtain any information throughout the course of my examination and treatment as needed to process any claims on my behalf. I permit NOMS Healthcare to send me any information via email or by calling the telephone number (s) I have authorized, regarding my account, treatment, appointments and/or any advertisements or specials offered by the offices. In the event that I cannot be reached directly, I give my consent for NOMS Healthcare to leave a message on my voicemail, answering machine or with any individual who answers any of the telephone numbers I've provided.

I give permission for the following individuals to receive my medical information:

(name)	(relationship)	(phone number)	(leave message Yes/No)

PAYMENT AUTHORIZATION

I HEREBY AGREE TO PAY ANY AND ALL CO-PAYS, DEDUCTIBLES, CO-INSURANCE, AMOUNTS OVER UCR, AND/OR EXCLUDED CHARGES FROM INSURANCE COMPANIES WITH WHOM NOMS HEALTHCARE DOES NOT ACCEPT ASSIGNMENT, AND ANY AND ALL CO-PAYS, DEDUCTIBLES AND CO-INSURANCE WITH THOSE THEY DO ACCEPT ASSIGNMENT.

I hereby request my insurance carrier to pay on my behalf insurance benefits to NOMS Healthcare for services rendered. I understand this authorization will be effective until revoked in writing. I understand that if necessary, a credit bureau report may be obtained. NOMS Healthcare cannot be held responsible for collecting my insurance claim(s) nor for negotiating a settlement(s) on a disputed claim(s). NOMS Healthcare fees are not established by insurance companies. I am responsible for my account.

No Show Policy

I hereby understand that NOMS Healthcare has a posted No-Show Policy and that if I do not cancel an appointment 24 hours prior to the scheduled appointment, I may be subject to the fees associated with said policy.

Permission to Communicate with Your Primary Care Physician, Other Community Care Providers and/or Mental Health Providers

In order to ensure continuity of care, it is often necessary to communicate information to your primary care physician and other community care providers including mental health providers, and to your insurance company. These communications may include information about your medical treatment and mental health or substance abuse treatment. This information is limited to that which is necessary to the determination of coverage and the coordination of your care.

Many insurance companies require us to document whether or not you will allow your clinician to communicate with your primary care physician, Health Insurance Company and/or mental health providers.

Consent for RX Hub Inquiry

I herby provide my consent for NOMS Healthcare, LLC to obtain my Rx History using the SureScripts-RxHub network or the Ohio Automated Rx Reporting System (OARRS). I understand that this inquiry will provide my physician with an accounting of my medication history reported by Pharmacy Benefit Managers and retail pharmacies. I also understand that SureScripts-Rx Hub has certified that Rx History Capture follows strict security protocols to align with HIPAA requirements and respect patient privacy. All queries and responses are made automatically through secure system-to-system communications.

Imaging Radiation Exposure

Your physician has ordered a procedure, which requires the use of radiation. The radiation exposure enables the radiologist to view the area of interest and then submit a written report to your doctor. By signing below you give consent to have this procedure and any future procedures performed that requires radiation.

Health Information Exchange

We participate in one or more Health Information Exchanges. Your healthcare providers can use this electronic network to securely provide access to your health records for a better picture of your health needs. We, and other healthcare providers, may allow access to your health information through the Health Information Exchange for treatment, payment or other healthcare operations. This is a voluntary agreement. You may opt-out at any time by notifying Human Resources or the IT Department.

Signed ____ Date___________________