Document & Policy Acknowledgement

This packet has been designed to give you more detailed information about the documents and policies referenced in the Document Acknowledgement Form. By signing the Document Acknowledgement Form, you have agreed to the policies and information listed below.

Assignment of Benefits:

I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to Cornerstone Family Healthcare (CFH) for any medical services provided to me by that organization.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, the Health Care Financing Administration, my insurance carrier or other medical entity. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance company or other entity if requested. The original will be kept on file by the organization.

I understand that I am financially responsible to the organization for any charges not covered by my health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for products received.

Notice of Privacy Practices & HIPAA Acknowledgement:

We are committed to protecting your Personal Health Information (PHI) in compliance with the Federal and State Laws, including the Health Insurance Portability & Accountability Act of 1996 (HIPAA). The attached Notice of Privacy Practices states:

- Our obligation under the law with respect to your personal health information
- How we may use and disclose the health information that we keep about you.
- Your rights relating to your personal health information
- Our rights to change our Notice of Privacy Practices
- How to file a complaint if you believe your privacy rights have been violated
- Identity Theft prevention and Red Flag compliance
- The conditions that apply to uses and disclosures as described in this notice
- The person to contact for further information about our privacy practices

We are required by law to give you a copy of this notice and to obtain your written acknowledgement that you have received a copy of this notice.

You may request, in writing, how CFH may use or disclose your private information to carry out treatment, payment or health care operations. CFH is not required to agree with your request. However, if CFH does agree, then it is bound to abide by such restrictions.

Consent to Photograph for Electronic Health Record:

I have given consent to have my (or my child's) photograph taken by CFH. I understand that the photograph will be stored in my (or my child's) electronic health record for the purposes of identifying me as a patient and to help prevent identity theft. Children's photographs will be updated at each Well Child Visit. I understand that this consent is voluntary and none of my rights to confidentially or privacy is waived by my consent.