CENTRAL BUCKS SPECIALISTS, LTD
PRIVACY AUTHORIZATION

January 1, 2016

Dear Patient,

HIPAA (The Health Insurance Portability and Accountability Act) requires our office to obtain your permission to use or disclose your health information.

Central Bucks Specialists (CBS) creates electronic medical records about your health and the service that we provide to you. We understand that your medical information is personal to you and we are committed to protecting that information for you. Healthcare professionals- including doctors, nurses, and technicians- in the Doylestown Clinical Network (DCN) - may access your demographic information for the purposes of providing you care. You have the right to decline to participate in the DCN.

CBS is also a member of HealthShare Exchange of Southeastern Pennsylvania, Inc., (HSX), we may use or disclose your Personal Health Information to this Health Information Organization (HIO) and also to the HIO of the Commonwealth, The Pennsylvania Patient and Provider Network (P3N) . Other health care providers, such as physicians, hospitals and other health care facilities, may have access to this information for treatment, payment and other purposes, to the extent permitted by law. You have the right to "opt-out" or decline to participate in the Health Information Exchange (HIE). If you choose to opt-out of the HIE, we will not use or disclose any of your information in connection with HSX or P3N.

Your signature on this consent gives our office your permission to perform any tasks including but not limited to:

* Bill your insurance company
* Call prescriptions to your pharmacy
* Contact you by phone to confirm appointments
* Relay test result information to you over the phone, by mail, or as a message left on answering machine
* Speak with any professional provider regarding your medical condition if warranted for coordination of care.
* Communicate with the following family member(s): provide name and relationship

_____

Name Relationship

_____

Name Relationship

I acknowledge that I was presented with a copy of the Notice of Privacy Practices for Central bucks Specialists. I have read the above health information disclosure guidelines and agree to them without restriction. Thank you for allowing us the opportunity to participate in your health care.

Sincerely,
Central Bucks Specialists, Ltd.

Name (print)_____ Date_____

Patient Signature_____ Date of birth_____

Email;_____

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CENTRAL BUCKS SPECIALISTS, LTD

FINANCIAL POLICY

Central Bucks Specialists strives to provide optimal medical care for all of our patients. This is our first priority. To provide this care we must accurately schedule our physicians, nurses and support staff. We commit to provide these resources to you. We ask that you let us know if you cannot make a scheduled appointment and we also ask you to provide needed referrals.

In order to provide all our patients with the physician and staff resources they need, we ask you to comply with our policies.

1. Please call at least **24 hours in advance** if you cannot keep an **office** appointment. If you do not, you will be billed a **$25.00** missed appointment charge for the office visit.

2. Please call at least **48 hours in advance** if you cannot keep an appointment for a **test or procedure**. If you do not, you will be billed a **$50.00** missed appointment charge for the test or procedure.

3. You are responsible for any **co-pay** required by your insurance. This payment is due **at the time of your visit.** We accept cash, checks and credit cards (we do not accept American Express) or debit cards for payment. Failure to pay your co-pay at the time of your visit will result in an **additional $10.00** charge on your billing statement.

4. If your insurance policy requires a **referral**, you are required to provide one at the time of your visit. If you do not have a referral, you may be seen, however you will be charged for the visit at the time of the visit. If you obtain the referral after the visit, we will adjust your account. You will be given an opportunity to re-schedule your appointment if you wish.

5. A fee of **$25.00** will be charged for completion of initial disability forms. This fee is payable upon request. Subsequent disability verifications require a fee of **$10.00.**

6. A fee of **$10.00** is charged for patient requested copies of complete charts.

7. A fee of **$25.00** is charged for any check returned to us for insufficient funds.

8. A fee of **$20.00** is charged for patient accounts if they are delinquent and in collections.

Patient Name	Patient Signature	Date

Revised 4/2016