D.O.B_____ Office Use (P#)_____

CENTRAL OHIO PRIMARY CARE

Receipt of Notice of Privacy Practices

I have been offered the HIPAA Notice of Privacy Practices at COPC which outlines my privacy rights and how COPC may use and disclose Protected Health Information about me.

□ Yes □ Offered but Decline Initials: _____

Photograph for Patient Identification

I give my consent to the use of my photograph for identification on my electronic health record. □ Accept □ Decline Initials: _____

Telephone Contacts, Monitoring and Recording-this does not include calls related to appointments, billing, or health-related information

I hereby consent and agree that: (1) any calls with COPC may be monitored and/or recorded and that COPC (or anyone acting on COPC's behalf) may contact me, from time to time, regarding my account (including for collections purposes or related to insurance coverage) or regarding my most recent visit with my provider; (2) any and all of COPC's contacts with me may be made via text message or with an automated dialing device; (3) COPC may contact me at any telephone number I provide to them, whether a residential, business number, or mobile number; (4) COPC may e-mail newsletters informing me of new services or suggested health screenings; and (5) I have an established business relationship with COPC and COPC may contact me in any of the ways described above. I understand that, if I accept now, I may opt-out at any time by notifying the COPC EHR Department.

□ Accept □ Decline Initials: _____

Health Information Exchange (HIE)

COPC participates in one or more Health Information Exchanges (HIEs) that share medical information to facilitate improved care through a comprehensive health record. This information is secure and only available to those providers involved in your care delivery. (For example, if you go to the Emergency Department, providers at the Emergency Department can pull your relevant health information from the HIE in order to better treat you.) I agree that my COPC provider may allow access to my health information through the Health Information Exchange for treatment or other health care operations. This is a voluntary agreement. I understand that I may opt-out at any time by notifying the Compliance Department via the HIE Opt-Out form located on the COPCP website.

Pursuant to Ohio law all patients are automatically enrolled in the HIE unless an opt-out form is completed and submitted to the Compliance Department. Please allow 10 business days for processing.

Confidential Communications

I understand COPC will notify me if COPC is unable to comply with my request for Confidential Communications.

Release of Protected Health Information in Emergency Situation

I understand that my protected health information may be released as my physician determines appropriate in an emergency situation.

Insurance Assignment and Acknowledgement

I understand my insurance carrier can choose to assign benefits to COPC or my Insurance carrier may make a payment directly to me. I understand and certify I am financially responsible for all health care service charges that are paid to me directly or by my insurance carrier as well as any applicable co-payments, co-insurance, deductibles and/or charge for non-covered service provided to me or to any of my dependents. I am also responsible for providing up-to-date and accurate insurance information.

Medicare and Medicaid: *I certify the information given by me in applying for payment under Title XVIII of the Social Security Act is correct.*

I authorize any holder of medical or other information about me to release to the Social Security Administration, Medicare, Medicaid, and/or its intermediaries/carriers, as well as my commercial insurance carriers any and all information required for claim consideration and payment. I certify that I will pay to COPC any co-payments, co-insurance, deductibles or non-covered services. I will immediately pay to COPC any payments that I receive from my insurance carrier for services provided to me and/or my dependents. I will also be responsible for any amounts not paid by my insurance for my failure to provide the appropriate insurance information for billing.

By signing below, I am acknowledging that I have read and understand the above statements.

_____	_____	_____
Patient Printed Name	Patient Signature	Date Signed
_____	_____	_____
Legal Guardian Printed Name (*if applicable*)*	Legal Guardian Signature (*if applicable*)*	Date Signed

PLEASE PROVIDE A COPY OF LEGAL GUARDIANSHIP COURT PAPERS FOR THE PATIENT'S RECORD.