Plateau Pediatrics

General Agreement to Use and Disclose Protected Health Information

_____ I have received, read, and understand the Plateau Pediatrics Patient Information brochure. I understand the stated policies of this practice and I agree to be bound by their terms. I also understand and agree that such terms may be amended from time to time by the practice.

_____ I have received and reviewed a copy of Plateau Pediatrics' Notice of Privacy Practices, which describes how patient health information may be used and disclosed. I understand that Plateau Pediatrics reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to *Plateau Pediatrics, Privacy Officer, 3234 Miller Avenue, Crossville, Tennessee 38555*. The most up-to-date Notice of Privacy Practices is also located on the practice website at *www.plateaupediatrics.com*. If I have a complaint regarding privacy or other issues, I understand that I may complain to the HIPAA Privacy Officer.

_____ I authorize Plateau Pediatrics, its clinicians, and its employees to use and disclose Protected Health Information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). If I do not sign this consent, Plateau Pediatrics may decline to provide treatment.

_____ I have the right to request that Plateau Pediatrics restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

_____ I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

_____ I authorize Plateau Pediatrics to process my insurance claims and understand they may use a photocopy of my signature for this purpose. I authorize Plateau Pediatrics to release any medical or other information necessary to my insurance carrier. If I am covered by or eligible for TennCare, Plateau Pediatrics may release protected health information to the Bureau of TennCare. I authorize and direct my carrier to issue payment check(s) directly to Plateau Pediatrics. Regardless of my insurance benefits, I understand that I am fully financially responsible for any and all fees incurred, and I agree to pay such fees in full when permitted by my insurance carrier. I agree to pay all collection costs, court costs, and attorney fees incurred to collect my account.

_____ The insurance information I have provided represents a full disclosure of the insurance/third party benefits to which I am entitled. I understand that failure to disclose any and all plans to which I subscribe may cause me to incur full liability for professional charges, as a result of non-payment by any carrier.

_____ If my address, telephone number, insurance, or legal custody status changes for any reason, I agree to let Plateau Pediatrics know immediately.

Minor children for whom I am legally entitled to make this agreement (list full names):

Parent/guardian's name: _____ Relationship: _____

Signature: _____ Date: _____