

ADULT (18 & over) PATIENT UPDATE

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND COMMUNICATION PERMISSIONS FORM

OLNEY PEDIATRICS
18111 PRINCE PHILIP DRIVE SUITE 311
OLNEY, MD 20832
(301) 774-4100

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain privacy rights regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of Olney Pediatrics' Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that federal law permits Olney Pediatrics to use my protected health information ("PHI") for a variety of purposes including, but not limited to, treatment, to obtain payment, for healthcare operations, and when required by law or for public health purposes. I understand that Olney Pediatrics may need to contact my guarantor (person responsible for payment of my medical bills) and/or the policy holder for my insurance to exchange information, when necessary for the purpose of obtaining payment. By signing this form I acknowledge and consent to these practices.

I understand that I am ultimately responsible for payment of my medical bills. I agree to pay all copays and charges not covered by my insurance. In addition, the following person is delegated responsibility for my medical bills (guarantor: usually a parent whose insurance policy covers me) and may communicate with Olney Pediatrics about bills:

_____	_____
<u>Guarantor</u>	Date of Birth (of guarantor)
_____	_____
My signature	Today's date
_____	_____
My printed name	Date of birth

I give permission for physicians and staff from Olney Pediatrics to communicate with me by my street address on record and (*check all allowed; circle first choice*):

- | | |
|--|--|
| <input type="checkbox"/> email address _____ | |
| <input type="checkbox"/> cell phone _____ | <input type="checkbox"/> okay to leave voicemail on cell |
| <input type="checkbox"/> home phone _____ | <input type="checkbox"/> okay to text cell (<i>nonsensitive</i> communications only*) |
| | <input type="checkbox"/> okay to leave voicemail at home |
| | <input type="checkbox"/> okay to leave message with family/other |

I give permission for Olney Pediatrics to speak to _____ at phone _____
or _____ at phone _____ regarding (*can check none, any, or all; these permissions may be changed by you at any time*):

- | | |
|--|---|
| <input type="checkbox"/> scheduling appointments | <input type="checkbox"/> routine lab results (*excludes drug, pregnancy, and STD tests) |
| <input type="checkbox"/> medication refills | <input type="checkbox"/> concerns raised by your parent |