Siena Proactive Internal Medicine

Deborah S. Blenner, M.D.

A Member of Catholic Health Services of Long Island

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the facility and the facilities listed at the beginning of this notice, and how I may obtain access to control this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV related information, sexually transmitted diseases, alcohol and substance abuse information, mental health information and genetic information.

X_____ _____

Signature of Patient or Personal Representative | Print Name of Patient or Personal Representative

_____ _____

Description of Personal Representative's Authority | Date

_____ _____

Signature of Facility Representative | Date

Express Authorization for the Disclosure of Protected Health Information

I have been advised of my rights to obtain access to and control my Protected Health Information. I also understand that in providing treatment, submitting billing and conducting healthcare operations. Siena Proactive Internal Medicine may need to discuss my protected health information to members of my family or certain close personal friends. By providing the requested information below, I further authorize disclosure of my protected health information as follows:

If I am unavailable, I expressly permit Siena Proactive Internal Medicine to disclose my protected health information for the purpose of appointment/test/procedure and follow-up to the following individuals:

X_____ _____

Name and Relationship to me | Phone

I expressly permit Siena Proactive Internal Medicine to disclose my protected health information for the purpose of appointment/test/procedure reminders and follow-up by leaving such information in the form of a message on the following recorded media:

Home Answering Machine: _____ Telephone Number: _____

Cell Phone: _____ Telephone Number: _____

Signature of Patient/ Personal Representative/ Parent or Guardian:

X_____

Catholic Health Services of Long Island
At the heart of health

Patient Authorization, Assignment of Benefits & Financial Agreement

I acknowledge and understand that by signing below, I hereby authorize payment directly to Siena Proactive Internal Medicine, Dr.Deborah S. Blenner, MD |45 Terry Road, Suite B Smithtown, NY 11787 |**for services rendered to me, as specified more fully below.**

1. MEDICARE :

- I authorize my Medicare benefits to be paid to the Practice for services furnished to me by the Practice.
- I authorize the Practice to release to the Centers for Medicare and Medicaid Services (CMS or Medicare) and its agents any information needed to determine my Medicare benefits or the benefits payable for related services.
- I authorize the release of medical information necessary to complete any insurance claim forms and to pay the claim.
- The Practice accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for any deductible and/or co-insurance payment and payment for any non-covered services. Co-insurance and deductibles for covered services will be based upon the charge determination of the Medicare carrier.
- I authorize the release of my information to any MediGap or other health insurance carrier I maintain and authorize payment of these secondary insurance benefits to be made on my behalf to the Practice, if possible.
- My authorization will remain in effect unless I revoke my authorization in writing.

2. OTHER INSURANCE PLAN PARTICIPATION: The Practice maintains a list of its contacts with health care service plans ("Plans"), which identifies the Practice physicians who participate in each Plan. A copy of the current list is available from the practice at the address, telephone number and/or website listed above.

- I have been informed whether any services rendered to me by the Practice may be provided by a non-participating provider and, if so, (i) that such services by a non-participating provider may result in costs not covered by the Plan and (ii) I am individually obligated to pay the full charges for all such services.
- I understand that the Practice has no contract, expressed or implied, with any Plan that does not appear on the list.
- I have been informed that I am individually obligated to pay the full charges for all services rendered to me by the Practice if my Plan does not appear on the list of Plans maintained by the Practice.

3. NON-COVERED SERVICES: I understand that each Plan (i.e. HMOs, PPOs) defines what items and services are covered and what items and services are not covered by the Plan.

- I understand that I will receive an Advanced Beneficiary Notice (ABN) from the Practice for services that are not or may not be covered by my Plan, and that I will be given the option to accept or decline any non-covered services.
- I accept full financial responsibility for payment for any potentially non-covered services that I have accepted, as reflected on the ABN, if my Plan determines that such service is not covered. Examples of non-covered services include, but are not limited to, services not specified as being covered by a Plan, services not listed in the benefit summary furnished to patients by the Plan, and/or treatment or tests not authorized by the Plan.
- I agree to cooperate with the Practice to obtain all necessary authorizations required by my Plan.

4. RELEASE OF INFORMATION:

- I understand that the Practice may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicate disease, or HIV, (1) to any person or corporation that is or may be liable or under contract to the Practice for reimbursement for services rendered, and/or (2) to any health care provider for continued patient care.
- I understand that the Practice may also disclose on any anonymous basis any information concerning my care that is necessary or appropriate for the advancement of medical science medical education, medical research and/or for the collection of statistical data or pursuant to State or Federal law.

5. FINANCIAL AGREEMENT:

- In return for the services provided to me the Practice, I will pay my account at the time service is rendered to me or will make financial arrangements satisfactory to the Practice for payment.
- If my account is sent to an attorney for collections I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action.
- If my account is delinquent, I may be charge interest at the legal rate. I assign to the Practice any benefits of any type under any policy of insurance that insures me or any other party liable to me.
- If my insurance company or Plan designates copayments and/or deductibles, I will pay such copayments and/or deductible amounts to the Practice.
- **I agree to be primarily responsible for the payment of the Practice's bill.**

X_____ _____

Beneficiary Signature or Authorized Party Date