Hermitage Family Practice

HIPAA – Financial Agreement

Name: _____

Date of Birth:_____

I give my consent for Mid TN Medical Hermitage d/b/a Hermitage Family Practice, to use & disclose protected health information (PHI) about me to carry out treatment, payment & health care operations (TPO).

Have you been provided a copy of the Notice of Privacy Practices?
____ Yes ____ No

Are we allowed to leave a message on your primary phone regarding medical information?
(including, appointments, referrals, billing information, test and lab results, etc.)
____ Yes ____ No

Is there anyone *other than yourself* that we can give your lab and test results to over the phone? ____ Yes ____ No

If so, please list name, relationship and contact phone number:
_____

May we mail a copy of lab and test results if **no one can be reached** by phone? ____ Yes ____ No

I give permission to communicate by secure patient portal/email regarding medical information including appointments, referrals, billing information, test and lab results. If there are any questions, I will call the office during regular business hours.
____ Yes ____ No

E-mail Address: _____

I agree to pay any and all unpaid balances including but not limited to the principal balance of my bill. If I am turned over to a collection agency or attorney for collections, I agree to pay those collections agency fees, attorney fees and court cost.

_____ _____

Signature (Parent or legal guardian must sign if under 18) Date