MICHEL E. AKL, MD
NATHAN DOSSEY, F.N.P.
NORTHERN ALLERGY & ASTHMA
4519 MILITARY ROAD NIAGARA FALLS, NY 14304

**This notice describes how past medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully…*

NOTICE OF PRIVACY PRACTICES

The health insurance portability and accountability act of 1996(HIPPA) is a federal program that requires a lot of medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally are kept properly confidential. This act entitles hat misuse personal health information.

As required by HIPPA we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your medical records only for each of the following purpose treatment, payment, and health care operation.

- Treatment means providing, coordinating or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment
- Health care operation include the business aspects or running our practices, such as conducting quality assessment and improvement activities, auditing, functions, cost-management analysis and customer service. An example of this would be an internal quality assessment review.

We may also create and dispute de-identified health information by removing all references to individually identifiable information.

We may also contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer

- The right to request restriction on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends or any other person identified by you. We are, however not required to agree to requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications or protected health information from us by alternative means or alternative locations.
- The right to inspect and copy protected health information
- The right to amend your protected health information
- The right to receive an accounting of disclosures of protected health information
- The right to obtain a paper copy of this notice from us upon request

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 1st, 2020 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of out Notice of Privacy practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office or with the Department of Health & Human services, Office of Civil Rights, about violations of the provisions of this notice of the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information about "HIPPA" or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619- 0257
TOLL FREE: 1-877-898-8775

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PATIENT REGISTRATION FORM **Patient Portal Email: _____**

Last Name_____ First Name_____ Mi_____

Street_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____

Marital Status: Single_____ Married_____ Widowed_____ Divorced_____

Dob_____/_____/_____ SSN_____-_____-_____

Ethnicity: Non-Hispanic Or Non-Latino_____ Hispanic/Latino_____

Race: White_____ Black_____ Asian_____ Hispanic_____ Other Race_____

Emergency Contact_____ Relationship_____ Ph:_____

Patients Employer_____ Ph:_____

Pharmacy_____ Location_____

Primary Care Physicians_____ Ph:_____

List of Names That May Receive Access To Medical Records, Other Than PCP

1._____ 2._____

_____ _____

Guarantor understands that any checks returned for insufficient funds will be charged a fee of $25.00 in accordance with New York State Obligation Law 11-104 and agrees that if the account should be turned over to collections the applicant will pay all cost of collection, which includes but are not limited to: collection fee up to 40%, reasonable attorney fees, court cost, filing fees and service fees.

I hereby authorize the release of medical or other information necessary to process insurance claims. I also authorize payment of medical benefits to Northern Allergy and Asthma 4519 Military Road Niagara Falls, NY 14304 for services rendered

Guarantor Name:_____ Signature:_____

Address:_____ City:_____ State:_____ Zip:_____

Sex: M____ F_____ Phone: (_____)_____ - _____ Cell: (_____)_____ - _____

SSN of Authorized Party: _____-_____-_____ DOB: _____/_____/_____

Today's Date: _____/_____/_____

NORTHERN
Allergy & Asthma

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the health insurance portability & accountability act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- **CONDUCT, PLAN AND DIRECT MY TREATMENT AND FOLLOW UP AMONG THE MULTIPLE HEALTHCARE PROVIDERS WHO MAY BE INVOLED IN THAT TREATMENT DIRECTLY AND INDIRECTLY.**
- **OBTAIN PAYMENT FROM THIRD-PARTY PAYERS.**
- **CONDUCT NORMAL HEALTHCARE OPERATIONS SUCH AS QUALITY ASSESMENTS AND PHYSICIAN CERTIFICATIONS.**

I have received, read and understand your notice of privacy practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at anytime at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how private information is used or disclosed to carry out treatment, payment or health care options. I also understand you are not required to agree to my request restrictions, but if you do agree then you are bound to abide by such restrictions.

PATIENT NAME: _____

RELATIONSHIP: _____
(IE: Self, Mother, Father, POA, ECT)

SIGNATURE:_____

PRINTED NAME: _____

DATE: _____/_____/_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledge on this Notice of Privacy Practices Acknowledgement, but was unable to do so as document below:

DATE:	INITIALS:	REASON:

Financial Policy

Northern Allergy and Asthma is dedicated to providing the best possible care for you. Additionally, we would like you to completely understand the following payment policy.

All co-payments, co-insurances, deductibles and past due balances are expected at the time of service.

CANCELLATION OF AN APPOINTMENT:

The patient is required to notify our office at least 24 hours in advance if you need to reschedule or cancel an appointment or a $15.00 cancelation fee will be charged. We will also charge a fee for any patient who skips an appointment without calling in advance. This no-show fee is $35.00 for standard office visit.

PAYMENT DUE AT TIME OF APPOINTMENT:

Payment is required at the time services are rendered. This practice accepts cash, personal check, money order, credit cards and debit cards. There is a service charge of $35.00 for returned checks. If you have a past due balances, any amount paid will be applied to the past due balance first.

Most insurance plans require co-pay to be paid by the insured patient for office visits and for other specified services such as tests and injections; therefore, there may be more than one co-pay required. Any questions you might have regarding co-payments due should be directed towards your insurance company.

Patients with an outstanding balance of 120 days overdue must make arrangements for payment prior to scheduling appointments. These accounts may be turned over to a collection agency unless prior arrangements are made with out billing service. Patients will be responsible for legal/collection fees. We realize that there may be financial difficulties; our billing service department has financial hardship and payment plan forms available.

INSURANCE PLAN PARTICIPATION:

Northern Allergy and Asthma participates with many insurance companies. It is the patient's responsibility to be aware of their insurance coverage, policy provisions, authorizations requirements, as well as network providers if applicable.

Due to relationships between insurers, third part administrations and "umbrella" networks, patients are strongly advised to contact their insurance carrier for participating provider information.

We bill non-participating insurance companies as a courtesy to you. If we have not received payment from a non-par insurance company within 60 days of the date of service, you will be expected to pay the balance. We will provide you with all the necessary information for submitting claims to your insurance company.

If you have insurance coverage with a plan that does not cover mid-level (burse practitioner or physician assistant) services or authorize us to bill under a supervising physician, it is your responsibility to make an appointment with a physician or to pay for services provided by a mid-level.

SELF PAY PATIENTS

If you do no carry insurance, you are considered a “Self Pay” patient, which means that you are expected to pay in full for any treatment. If you are unable to pay for you visit in full at the time of your appointment, please make suitable arrangements prior to your visit with out billing company, Assertive Medical Practice Management, Inc. You may reach out to them at 716-608-5531. The charges for your visit will be quoted when your appointment is made. Please be sure you request this information if it is not offered to you.

ASSIGNMENT OF BENEFITS

I acknowledge financial responsibilities for all facility and physician/provider(s) fees. I understand that the physician billing office will file my insurance claim and I assign direct payment to the physician of all payment made under the terms and provisions of my policy. I further understand that any disputes on coverage are between my insurance carrier and me and I will be responsible for payment for denied services regardless of the outcome of my dispute. I acknowledge financial responsibility for all charges if inaccurate insurance information is given at the time of service and the information is not corrected prior to my insurance company’s timely filing limit.

We encourage our patients to discuss their financial circumstances with our billing company, Assertive Medical Practice Management, Inc. They will be happy to assist you with questions and payment plans. You many call them directly at 716-608-5331.

I have read the above financial policy and agree to comply with their terms.

COLLECTION AGENCY FEES

Outstanding Balances: Accounts that are mailed more than two invoices may be sent to collections; A 33% fee will be added to all Accounts sent to Collections. Accounts sent to collections may result in discharge from the practice

PATIENT NAME: _____

RELATIONSHIP: _____
(IE: Self, Mother, Father, POA, ECT)

SIGNATURE:_____

PRINTED NAME: _____

DATE: _____/_____/_____