

## **Authorization and Consent**

**Consent for Medical Treatment:** I authorize Osteopathic PDX to provide ongoing medical care, treatment and procedures as needed. I acknowledge that no guarantee has been made to me as to the results that may be obtained from this medical care, treatment, procedure or prescribed medication. If the health care services I am requesting require multiple visits, I consent to all necessary routine treatment prescribed while receiving medical care at Osteopathic PDX

**Financial Agreement:** All accounts are due and payable at the time of your visit unless arrangements have been made with Greg Esmer, D.O. On accounts that have established arrangements, the payment is due upon receipt of the monthly statement. If collection procedures are required, I am responsible for their cost. If I have an insurance claim pending, I will receive a monthly statement for the outstanding balance on my account. I understand that Osteopathic PDX is under no responsibility to collect an insurance claim or to negotiate a disputed claim. I understand that I am responsible for charges not covered by my insurance or other agency, which may include deductible and coinsurance. If insurance payment is not received after 30 days, the balance in full becomes my responsibility. I agree I am the responsible party and in the event additional costs and/or fees are incurred in connection with the collection of my account, I will pay all such costs and fees, including collection costs, attorney fees, all court costs, NSF check fees (\$25 per NSF check). I understand that the quote of benefits provided from my insurance company to Osteopathic PDX may not be completely accurate. I understand that I will first discuss with my insurance company any questions that arise regarding my coverage or benefits. I agree to be personally, financially liable for all charges for all services provided by Osteopathic PDX that are outside of my insurance plan benefits. I understand that I retain the right to receive services from physicians and providers who are contracted with my insurance company and for which payment would otherwise be available.

**Assignment of Insurance Benefits:** I authorize payment directly to Osteopathic PDX of all insurance or health plan benefits. I certify that all information given in applying for payment under my health insurance plan is correct and authorize verification of coverage by Osteopathic PDX. Photocopy of this authorization shall be considered as effective and valid as the original.

**Cancellation Policy:** Appointments need to be cancelled 48 hours prior to

appointment date/time or a rescheduling fee of \$75 will be charged for follow-up visits and \$150 for initial visits. I have read and fully understand the above information, have asked questions about anything not clear to me and am satisfied with the answers I have received. I understand I may revoke this consent at any time.

### **Osteopathic PDX Notice of Privacy Practices**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

**If you have any questions about this Notice please contact our Privacy Officer, Dr. Greg Esmer, DO, 503-970-2303.**

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

### **How We May Use and Disclose Health Information About You**

**Treatment:** To provide better health care, we may discuss treatment and management options with other health care providers. For example, we may discuss with another health care provider how your injury relates to your overall health.

**Payment:** Your protected health information may be used and disclosed, as needed, to obtain payment for your health care services provided by us. For example, we share information about your last appointment with your insurer in order to bill for our services.

**Health Care Operations:** We may use or disclose, as needed, your protected health information in order to support Osteopathic PDX to ensure our patients receive quality health care. For example, we may use your health information in evaluating the performance of our staff in caring for you and how to better care for you.

We may share your protected health information with third party “business associates” that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

### **Special Situations**

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

**To Avert a Serious Threat to Health or Safety:** We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

**Required By Law:** We will disclose health information about you to the extent required by federal, state or local law.

**Public Health Risks:** We may disclose health information about you in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products as permitted by law.

**Health Oversight Activities:** We may disclose protected health

information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

**Legal Proceedings:** We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

**Law Enforcement:** We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons, or similar process, subject to all applicable legal requirements.

**Coroners, Funeral Directors, and Organ Donation:** We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

**Military, Veterans, National Security and Intelligence:** If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

**Workers' Compensation:** We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

**Family and Friends:** We may disclose health information about you to friends and family if we obtain a verbal agreement to such a disclosure or if we give you an opportunity to object and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you

bring your spouse with you into the exam room during treatment or while treatment is discussed.

### **Other Uses and Disclosures of Protected Health Information**

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written authorization. Examples of disclosures requiring your authorization include disclosures to your partner, your spouse, your children and your legal counsel.

### **Uses and Disclosures That Require Us to Give you the Opportunity to Object**

Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

### **Electronic Communication**

Electronic communication such as email is not considered secure. Considering this, we will only communicate with you via electronic communication given your verbal or implied agreement, based on our professional judgment. An example of this is an email asking us to supply you with another healthcare provider for adjunctive treatment. We will also limit our use of your protected health information via electronic communication except as required to fulfill your request or treatment goals.

## Your Rights

For any questions about your rights (listed below) or to make any requests regarding your health information please contact our Privacy Officer, Greg Esmer, DO at 503. 970.2303.

**Right to inspect and copy.** You have the right to inspect and obtain a copy of protected health information about you regarding medical and billing records and any other records that your physician uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

This right may be limited by federal law with regards to notes and information compiled for use in or anticipation of civil, criminal, or administrative action or proceeding. Depending on the circumstances, a decision to deny access may be reviewable and you may ask to have this decision reviewed.

**Right to Amend.** You have the right to ask us to amend health information about you that you believe is incorrect for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**Right to an Accounting of Disclosures.** You have the right to request an “accounting of disclosures.” This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment, health care operations, when specifically authorized by you and a limited number of special circumstances involving national security, correctional institutions and law enforcement.

**Right to Request Restrictions.** You have the right to ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the

restriction to apply.

We are not required to agree to a restriction that you may request. If we do agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment.

**Right to Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

**Right to a Paper Copy of this Notice.** At any time you may request a paper copy of this notice.

### **Breach of Health Information**

We will inform you if there is a breach of your health information.

### **Complaints**

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer, Greg Esmer DO, at 503.970.2303 for further information about the complaint process.

This notice was published and becomes effective on December 19, 2013.