Notice of Privacy for:
Patient's Protected Health Information

This notice describes how health care information about you may be used and disclosed and how you can get access to this information. Please review it carefully.
This office uses and discloses your protected health care information for the following reasons:

- To share with other treating health care providers regarding your health care.
- To submit to insurance companies or Worker's Compensation to verify that treatment has been rendered.
- To determine patient's benefits in a health care plan.
- Releasing information required by State or Federal Public Health Law.
- To assist in overcoming a language barrier when caring for a patient.
- Business assoc. sending written assurances for your privacy have been attained.
- Emergency situations. Abuse, neglect, or domestic violence.
- Appointment reminders to household members or answering machines.
- To send out birthday cards and newsletters.

Any other uses or disclosures will only be made with your specific written prior authorizations.

You have the right to:

- Revoke authorization, in writing at any time by specifying what you want restricted and to whom.
- Speak to our privacy officer who is Krissy and can be reached at FCC regarding privacy issues, to render a complaint to our privacy officer.
- Inspect, copy and amend your protected health information and amend it as allowed by law.

This office reserves the right to change the terms on this notice to make new notice provisions for all protected health information that it maintains. Patients may also get an updated copy upon request at any time by asking the staff.
I acknowledge that I have received and reviewed this notice with full understanding.

One Time Authorization

I hereby authorize FCC to furnish information to insurance carriers concerning my illness & treatments and I assign to same all payments for medical services rendered to me. I understand that my insurance will be billed as a courtesy and **I agree to be financially responsible for any balance due to FCC.** I also authorize FCC to perform any treatment which is considered medically necessary by the Dr. A photocopy of the authorization and assignment shall be considered as valid as the original.

CANCELLATION POLICY

If you are unable to keep your scheduled appt. please give 24-hour notice. There will be a $25.00 charge for every missed or no show appt. Thank you for your cooperation. I acknowledge and understand the above statements.

Signature or Legal Guardian Date