MINNESOTA
HEAD & NECK
PAIN CLINIC

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____
Address: _____
Telephone: _____Email:_____
Patient Number: _____Social Security Number: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.
Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.
You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Tia Reichert
Telephone: 763-577-2484 Fax: 763-577-1375
E-mail: tiar@mhnpc.com
Address: 3475 Plymouth Blvd. Suite 200 Plymouth, MN 55447

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information (THIS MAY INCLUDE PSYCHOLOGY NOTES) to carry out treatment, payment activities and heath care operations.

Signature: _____ Date: _____
If this Consent is signed by a personal representative on behalf of the patient, complete the following:
Personal Representative's Name: _____
Relationship to Patient: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04/15/2003, and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.
Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS
Access: *You have the right to look at or obtain copies of your health information, with limited exceptions.* Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $1.27 for each page, $16.82 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)
Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.
Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our *agreement (except in an emergency).*
Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.
Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.
Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS
If you want more information about our privacy practices or have questions or concerns, please contact us.
If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.
We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a *complaint with us or with the U.S. Department of Health and Human Services.*

Contact Officer: **Tia Reichert**

Telephone: **763-577-2484** Fax: **763-577-2484**

E-mail: **tiar@mhnpc.com**

Address: **3475 Plynouth Blvd. Suite 200 Plymouth, MN 55447**

VERSION 11/2018

Missed Appointments and Late Cancellations Are Everyone's Problem.

A scheduled patient who fails to show up for their appointment interrupts the entire care giving process. Missed appointments represent a lost opportunity to better serve other patients who are in need of treatment.

Help us improve everyone's access to medical care.

Please try to keep your appointments. If you must change or cancel your appointment we require at least 24 hours notice of cancellation.
(A charge will be incurred for cancelations within 24 hours)

If you do miss an appointment, or cancel within 24 hours of your appointment, we will:

- Send you a bill for $55.00 missed appointment charge.
- Move you to restricted scheduling- if you continue to miss your appointments. At that point you will have to contact the Business Office directly to schedule any future visits.
- Dismiss you as a patient should you miss, or fail to cancel, your appointment while on restricted scheduling.

Help us improve everyone's access to quality care!

CREDIT POLICY

All charges from the Minnesota Head and Neck Pain Clinic, P.A. are billed to your insurance company from our office. You will receive a monthly statement showing any balance unpaid by insurance that you are responsible for. These balances are due upon receipt of your first statement. You may also be asked to pay these balances when scheduling or checking-in for an appointment.

As a patient courtesy, our office will call and request your pertinent insurance benefits related to our services prior to your appointment. If you have an unmet contract deductible, you will be asked to provide a down payment for your services at your first appointment. Although you may have insurance coverage, payments may begin with the first appointment, at the time of service, with collection of down payments on deductibles, co-pays or non-covered services.

Delayed payment by your insurance carrier is not a valid reason for delayed payment to the clinic. THE CLINIC DOES NOT ACCEPT RESPONSIBILITY FOR DETERMINING INSURANCE BENEFITS, nor does the clinic accept responsibility for collecting, or negotiating insurance claims. IF YOU ARE INSURED THROUGH AN H.M.O. AND REQUIRE A REFERRAL FOR TREATMENT, YOU ARE RESPONSIBLE FOR OBTAINING THOSE REFERRALS AS WELL AS PAYING ANY COPAYS.

If you are covered under Worker's Compensation, an Auto accident policy, or covered under any other legal situation, you must supply the clinic with all appropriate information including: case number, name of insurance company, address and phone; attorney's name and address and phone number. If this information is not given to us, you will be held responsible for the charges. Please NOTE: You are also responsible for any remainder of your bill following exhaustion of benefits by either Worker's Comp or Auto insurance. You may be eligible to have this remainder covered by personal health insurance and will need to provide that information as well at the time of your registration.

If you have Medical Assistance, you must present your card at each appointment in order for us to bill the *proper sources. If this information is not furnished to us, you will be held responsible for the bill.*

If a collection agency is retained you are responsible for all additional fees. Payment schedule is as follows:

Balance	Payment
$0-$500	$150.00
$501-$1,000	$175.00
$1,001-over	$200.00

CANCELLATION POLICY

Minnesota Head and Neck Pain Clinic is a multi-specialty clinic that provides one facility to treat and manage TMJ disorder as well as other chronic head and neck pain. When a patient is treated at this facility, he or she is usually scheduled with several clinicians, one after the other. Many patients are unaware of the impact on the clinic with last moment cancellations. The clinician has set aside a large block of time just for your appointment. Cancelling an appointment with less than 24 hours notice is not only discourteous to the clinician, but also to other patients who could have used the time.

Please be respectful in keeping your appointments and cancel with short notice only in the event of unavoidable circumstances. The charge for a missed appointment or last moment cancellation is $55.00 (not reimbursable by insurance companies).

Please note, if you require interpreter services the clinic is arranging for this service on your behalf and will incur a fee. Sign Language interpreters require 48-hour minimum notice for appointment change or cancellation and foreign language interpreters require 24-hour minimum notice. Should you find it necessary to change or cancel your appointment or fail to keep your appointment with interpretation services arranged, you will be billed accordingly for the cost of this service. (This does not apply for patients on public assistant programs.)
I have read and understand the credit and cancellation policies.

_____ _____

Signature Date