HIPAA PATIENT SUMMARY OF PRIVACY PRACTICES

The complete Notice of Privacy Practices is available online or by request printed.
I acknowledge the Notice of Privacy Practices and that I have read (or have had the opportunity to read if I chose) and understood the Notice.

Uses and Disclosures of Health Information We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers.

Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization

Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization

In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law.

Patient Rights

As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please feel free to contact us.

Patient's Name Printed: _____

Responsible Party (If not the patient): _____

Signature: _____ **Date:** _____

FINANCIAL POLICY

Thank you for choosing **Tampa Bay Sports Medicine Center (TBSMC) of Dr. Timothy C. Runyon DPM PA**. Please take the time to read through and sign our financial policy statement. Our practice is built on long term relationships with our patients and those relationships are based on communication and understanding.

Purpose: This is an agreement between **Timothy C. Runyon DPM PA**; the named patient and responsible party on this form. We appreciate you for selecting us as your Podiatrist. We want to be sure you fully understand your financial obligations for the services we will be providing. By signing this agreement, you are agreeing to pay for all services rendered.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance as well as any new charges to the account.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collections agency; if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Insurance: Insurance is a contract between you and your insurance company. We will bill your primary insurance company as a courtesy to you. Some insurance companies require you to stay within a specific network of podiatrists in order for them to pay for the services rendered or for the full benefit available to you. It is your responsibility to **check with your insurance company** to verify that your services will be covered here at **Timothy C. Runyon DPM PA**. Although we can estimate what your insurance company may pay, it is your insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance.

PPO's & HMO's: You will be responsible for any copays, deductibles, co-insurances and non- covered services. ****It is the patient's responsibility to verify that any required authorizations/referrals are in place prior to visit****

Minors: In case of minors, any required payment is expected at the time of service. Required payment is the responsibility of the person bringing the child in for treatment. In no case shall a parent be billed unless prior arrangements have been made directly with that parent.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or pay a portion of the treatment costs it is the authorizing parent's responsibility to collect from the other parent.

Past due accounts: If your account becomes past due we will take necessary steps to collect this debt. If we have to refer your account to a collection agency you agree to pay all the collection costs. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees which incur plus court costs. In case of suit you agree the venue shall be in Pinellas County Florida.

Returned checks: There is a fee (currently **$74**) for any checks returned by the bank.

Effective date: Once you have signed this agreement you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Patient's Name Printed: _____

Responsible Party (If not the patient): _____

Signature: _____ **Date:** _____

Authorization for Disclosure of Protected Health Information

Patient Name: _____ DOB: _____

Insurance: _____ Phone Number: (_____) _____ - _____

(Please leave it blank, we will fill out when you request it)

Release Information From:	**Release Information To:**
Name/Facility: _____	Name/Facility: _____
Address: _____	Address: _____
City/State/Zip _____	City/State/Zip _____
Phone: _____	Phone: _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Please leave it blank, we will fill out when you request it.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I may revoke this authorization at any time by sending written notice to the facility/provider releasing records. A revocation is not valid if (1) action was previously taken in reliance on this authorization, or (2) if this authorization was obtained as a condition for obtaining insurance coverage. **I authorize Dr. Timothy C Runyon, D.P.M. to disclose medical information** to the party identified in the "Release Information To" section. I understand this may include information regarding mental health, alcohol/drug use, and HIV treatment. **I understand that once disclosed, information may be re-disclosed by the recipient and no longer protected**. I understand this authorization is voluntary and that I may refuse to sign. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment, or my eligibility for benefits.

Patient's Name Printed: _____

Responsible Party (If not the patient): _____

Signature: _____ **Date:** _____

TIMOTHY C. RUNYON, D.P.M., PA
Podiatric Physician & Surgeon

FOOT & ANKLE CARE
DIPLOMATE, AMERICAN BOARD
OF PODIATRIC SURGERY

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Fax: 727-895-1215
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Patient Authorization Forms

I have read the **Notice of Privacy Practices**
By initialing I have read and understand the above_____

Authorization to Release Information
I consent to the use or disclosure of my protected health information by TAMPA BAY SPORTS MEDICINE CENTER (TBSMC) for the purpose of diagnosing or providing treatment to me, obtaining payment for my Health care bills or to conduct health care operations of TBSMC.
By initialing I have read and understand the above_____

Financial Agreement & Payment Policy
I understand that I am financially responsible for services rendered by TBSMC provider(s).
I also understand that few insurance carriers cover all costs for services rendered. TBSMC will submit claims to your insurance carrier. I will be responsible for the balance on my account that my insurance company does not cover. I will pay any co-payments, co-insurance, and deductibles at the time of service at TBSMC.
By initialing I have read and understand the above_____

Authorization for treatment
Throughout your treatment at TBSMC the medical provider(s) may order diagnostic testing (lab work, bone scan's, x-rays, MRI's, CT scans… etc.) that will help determine your diagnosis and future treatment. Failure to schedule or obtain the recommended diagnostic studies or failure to schedule a follow up visit in a timely manner to review the diagnostic studies and discuss the results will constitute as a breach of our recommendations. TBSMC employees and medical providers will not be held accountable for your lack of responsibility and purposeful disregard of our medical recommendations.
By initialing I have read and understand the above_____

I hereby authorize the medical staff of TBSMC to render medical services, treatments as deemed necessary and contact me to confirm my appointments, treatment and billing information. I understand that failure to comply with our medical recommendations is against medical advice. (AMA)
By initialing I have read and understand the above_____

By signing, I have read, understand and agree to comply with TBSMC policies so noted in the Notice of Privacy Practices (Notice).

Patient's Name Printed: _____

Responsible Party (If not the patient): _____

Signature: _____ **Date:** _____