BriteStar Primary Care and Weight Loss Clinic
1023 Northwest Hwy Garland TX 75041-5831

HIPPA Forms

The Health Insurance Portability and Accountability Act ("HIPPA") requires that all medical providers, insurance companies and others put in place controls to ensure that your personal medical information is safe. BriteStar Primary Care and Weight Loss Clinic requests that each patient sign this consent form which allows us to share protected health information with other physician offices, your hospital and insurance company. By signing this form you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent.

AUTHORIZATION TO RELEASE INFORMATION & TO PAY BENEFITS

Initial:_____ I authorize the provider to release any of my medical information, including drug and alcohol and HIV positive test results, to my insurance company(s), as needed to process my insurance claim. I authorize my insurance company to make payments directly to the provider for covered medical and/or surgical services.

Authorization to Release Information to Family Members

Initial:_____ Many of our patients allow family members such as their spouse, parents or others to call and request the results of test and procedures.

Under the requirements for the H.I.P.A.A., we are not allowed to give this information to anyone without the patient's consent. If you wish to have your test results released to family members you must sign this form. Signing this form will only give consent to release laboratory and radiology results to the family members indicated below. This consent form will not allow BriteStar Primary Care and Weight Loss Clinic Associates to release any other information to these family members.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize BriteStar Primary Care and Weight Loss Clinic Associates to release my laboratory/radiology results and all medical related reports to the follow individuals,

Name: _____

Relation to Patient: _____

Authorization to Leave Messages with Household Members/Answering Machine

Initial:_____ From time to time it is necessary for representatives of BriteStar Primary Care and Weight Loss Clinic to leave messages for patients. The purposes of these messages is to remind the patients that he/she has an appointment, to notify the patient that the medical staff would like to discuss lab or procedure results, or to ask a patient to call regarding an issue or concern. At no time will a representative of our clinic discuss your medical circumstances or condition without your consent. The purpose of this consent is to leave messages with members of your household or on your answering machine. Your have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Signature of Patient/Representative _____ Date: _____

Printed Name of Patient/Representative: _____

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FINANCIAL POLICY

OUR PRACTICE FINANCIAL POLICY

We are dedicated to providing you with the best possible care and service, and regard your understanding of our financial policy as an essential element of your care and treatment. To assist you, we have the following financial policy. If you have any question please feel free to discuss them with our staff. Unless other arrangements have been made in advance by either you or your health coverage carrier, full payment is due at the time of service.

YOUR INSURANCE

We have made prior arrangements with many insurers and other health plans. We will bill those plans with which we have an agreement and will collect any required co-payment at the time of the service. The co-payment will be collected when you arrive for your appointment. In the event your health plan determines a service to be not covered, you will be responsible for the complete charge. In that event we will bill you and payment is due upon receipt of that statement.

If you have insurance coverage with a plan with which we do not have prior agreement, we will prepare and send the claim for you, on an unassigned basis. In this case, your insurer will send the payment directly to you. Therefore charges for your care and treatment are due at the time of service.

We will also bill your health plan for all service we provide in the clinic. Any balance due is your responsibility and is due upon receipt of a statement for our office. Please be advised that there will be a $36 service charge for any returned checks.

MINOR PATIENTS

For all services rendered to minor patients, the adult accompanying the patient is responsible for the payment.

MISSED APPOINTMENT

In order to provide the best possible service and availability to all our patients, it is our policy to charge $25 for any appointments not cancelled at least one day prior. Please call us as early as possible if you know you will need to reschedule your appointment.

FINANCIAL AGREEMENT

In consideration of the patient receiving services from the Physician, I agree:

• I am responsible for all expenses for treating me (the patient).

• Payment of charges is due at the time of the appointment.

• If the Physician files my insurance for me, I agree to pay for non-covered insurance benefits, co-insurance, co-pays, and deductibles.

Signature of Patient/Representative:_____ Date:_____

Printed Name of Patient/Representative: _____

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CONSENT TO TREAT

I consent to treatment as necessary or desirable to the care of the patient named below, including but restricted to whatever drugs, medicine, performance of operations and conduct of laboratory, x-ray, or other studies that may be used by the attending physician, Nurse Practitioner or qualified designate. I also acknowledge full responsibility for the payment of such services and agree to pay for them, in full, at the time of service. If the physician must use a collection agency/attorney or court to collect its charges, then I will pay reasonable attorney fees and costs incurred in collecting same regardless of insurance coverage. I hereby authorize payment directly to BriteStar Primary Care and Weight Loss Clinic of the medical expense benefits otherwise payable to me but not to exceed my indebtedness to said provider on account of the enclosed charge. I have read and understand the financial policy of the practice and I agree to the bound by its terms that such terms may be amended from time-to-time by the practice.

Signature of Patient/Representative:_____ Date:_____

Printed Name of Patient/Representative: _____