

**Patient Consent for Use and Disclosure of Protected Health Information
As Required by the Privacy Regulations Created as a Result of the Health Insurance
Portability and Accountability Act of 1996 (HIPAA), Effective April 14, 2003.**

With my consent, VILLAGE MEDICAL CENTER may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Village MEDICAL Center's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. VILLAGE MEDICAL CENTER reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:
VILLAGE MEDICAL CENTER, 4775 W. Panther Creek Dr. #345, The Woodlands, TX 77381.

With my consent, VILLAGE MEDICAL CENTER may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including for example, laboratory results.

With my consent, VILLAGE MEDICAL CENTER may mail or e-mail to my home or other designated location any items that assist the practice in carrying out TPO such as appointment reminders and patient statements. I have the right to request that VILLAGE MEDICAL CENTER restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

FINANCIAL POLICY

Appointments: When making an appointment with one of our providers, it is your responsibility to make sure that the physician is under contract with your insurance plan. Failures to confirm that the provider you are seeing is not in your plan may result in being out of network and may make you responsible for the charges.

Please inform our receptionist at the time of making your appointment of any demographic changes, i.e. address, telephone number, insurance information, etc. There will be a delay in the event changes are given to the receptionist at the time of arrival instead of at the time of making appointment as it will be necessary to obtain insurance verification of coverage and benefits in addition to updating our records prior to being seen. Failure to notify us immediately of such changes in demographic information, financial status and/or insurance coverage may result in you being responsible for any services not covered by your insurance carrier.

As a courtesy, please arrive for your appointment at least 10 minutes prior. If more than 20 minutes late, it may be necessary to reschedule your appointment to another day in order to prevent inconveniencing other patients.

Upon arrival for each office visit, please be prepared to show the receptionist a copy of your most recent insurance card. You will be required to verify all demographic information upon check-in. This will include verification of name, address, telephone numbers and all insurance information. Failure to submit accurate information in a timely manner may result in you being responsible for balance due.

Upon checking-out, please be prepared to pay for current and/or previous balances on your account. Payment requested may consist of any out-of-pocket amounts associated with a current visit and/or a prior balance. For your convenience, we accept cash, check, credit cards, i.e. Visa and Mastercard. We will also schedule any future appointments necessary and arrange for referrals as requested by your provider. Please allow 24-48 hours for completion of most referrals.

Insurance plans may not cover AFTERHOUR charges that apply for appointments at and/or after 5:00pm Monday-Friday, on Saturdays, days designated as holidays, and as an emergency work-in during regular office hours, and you will be responsible for these charges.

Appointments are scheduled for the convenience of our patients and we strive to see our patients in a timely manner when available. If appointments that you do not need are not cancelled or rescheduled, this appointment time may not be available for a patient who needs to be seen at that time. This is especially true for appointments 30 minutes or longer which are considered extended appointments. Appointments that need to be cancelled or rescheduled must be done so by the close of the previous business day and can be done so by calling the office (281) 292-1192. Failure to contact our office to reschedule or cancel an extended appointment by the close of the previous business day will be subject to a charge of a minimal office visit which will be directly charged to you and is not covered by any insurance company.

Insurance: We are contracted with most insurance companies for your convenience. We will obtain insurance verification prior to your appointment based on the information provided. Insurance verification does not guarantee that your insurance carrier will pay for services provided. Payment of co-insurance, deductibles, and services not covered by your insurance is required at time of service. Balances not paid within 30 days of notification of insurance denial are subject to a \$15 service charge per month.

We allow 45 days from the date a claim is filed by our office for the insurance company to pay. If the insurance carrier has not paid within this time, you may be responsible for the entire balance, without further notice. We will not become involved in disputes between you and your insurance company regarding coverage and/or policy benefit criteria, i.e. deductibles, non-covered services, co-insurance, coordination of benefits, pre-existing conditions or "reasonable and customary" charges, etc. other than to supply factual information when necessary.

By signing this form, I am consenting to VILLAGE MEDICAL CENTER use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing anytime, except to the extent that the practice has already made disclosures in reliance upon my prior consent. If this consent is not signed, VILLAGE MEDICAL CENTER may decline to provide treatment. I have read, understood, and agree to the above HIP A A and Financial Policies. I hereby attest that I have given and agree to provide current patient and insurance information and authorize release of information necessary for insurance filing and pre-certification by signing this statement.

I, the Patient/Legal Guardian, hereby permit the following person(s) to have access to my medical records including lab results, x-rays, referrals, written prescriptions and sample medications: (Please check all that apply, and PRINT clearly the first and last names(s) for all the boxes checked.)

- Spouse: _____
- Parent/Legal Guardian: _____
- Caretaker: _____
- Other: _____
- No additional person(s) are authorized access to my protected health information without my express Written consent.

Print Name of Patient or Legal Guardian

Signature of Patient or Legal Guardian

Print Name of Minor Patient (under age 18)

Date