Alfred J. Poggi, D.O., Ltd
Christopher S. Poggi, D.O.
277 Neilan Road
Somerset, PA 15501

Patient Insurance /Payment Form

Primary Medical Insurance:

Policy Holder Name:_____ DOB:_____

Insurance Company:_____ Policy#:_____

Group #:_____Address of Insured:_____

Patient relationship to policy holder:_____

Secondary Medical Insurance:

Policy Holder Name:_____ DOB:_____

Insurance Company:_____ Policy#:_____

Group #:_____Address of Insured:_____

Patient relationship to policy holder:_____

I certify that I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to Alfred J. Poggi, D.O., Ltd. / Christopher S. Poggi, D.O. (AJPLTD/CSP) all money to which I am entitled for medical expenses related to the services performed from time to time by (AJPLTD/CSP), but not to exceed my indebtedness to AJPLTD/CSP. I authorize AJPLTD/CSP to release any medical information to my insurance carrier or third party to facilitate processing my insurance claims.

Medicare beneficiaries: I request that payment of authorized Medicare benefits be made to AJPLTD/CSP. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature of Responsible Party:_____ Date:_____

Printed Name of Responsible Party:_____Date:_____

Alfred J. Poggi, D.O., Ltd.
Christopher S. Poggi, D.O.
277 Neilan Road
Somerset, Pa 15501

Patient's Name:_____ **Soc. Security #** _____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Home Phone:_____ **Cell Phone:**_____ **Primary Contact: Home Cell** (circle)

DOB:_____ **Gender: Male Female (circle) Driver's License #**_____

Employer:_____ **Work Phone:**_____

Whom may we call in Case of Emergency? Name: _____

Relationship to Patient:_____ Primary Phone #:_____

Practice Policy: All payments are due at time of service rendered. This practice has a legal obligation to the insurance companies that we are contracted with to collect copayments, coinsurance and deductibles at the time of service. Once a balance reaches 90 days old without payment, the balance may be transferred to a third party, i.e. the local magistrate, for collections or other actions. Our office will obtain your insurance benefits; however, it is your responsibility to know your benefits per your contract with your health insurance carrier. It is your responsibility to provide our office with new insurance information prior to your appointment. There will be a $15 charge for filling out forms that require more than just a signature and for writing letters. Any prescription requests the office receives will be refilled with in 24 hours. Any request that is made after noon on Friday will not be completed until Monday. **All refills must be done before noon on Friday.**

Canceling/Rescheduling Appointments: If you are unable to keep your appointment, please notify our office at least 24 hours in advance to cancel or reschedule. Your courtesy will allow other patients seeking medical treatment the option to use your scheduled time. Once a year, we will allow one missed appointment without advanced notice; after that, $25 will be charged. This amount is not covered by insurance and will be billed directly to you.

After Hour Calls: Our office hours are Monday, Thursday and Friday 9am – 5pm. Tuesday 9am – 7pm Wednesday 9am – 1pm All routine matters should be handled during those times. However, if you believe your situation is critical, always go to an emergency room. Otherwise, call our office and the doctor will work you in. If you need the doctor's assistance after office hours, he may be contacted by calling the UPMC Somerset operator at (814)443-5000 and ask the operator to page Dr. Poggi for you.

I have read and understand the office and collection policies .

_____

Signature /Guardian Signature Printed Name Date

CONSENT TO USE AND DISCLOSURE OF INFORMATION FOR TREATMENT, PAYMENT OR OPERATIONS

I hereby consent to the use and disclosure of information in my medical records for treatment, payment and health care operations purposes. I understand that this consent is voluntary. I understand that information in my medical records may be used and disclosed to persons other than Alfred J. Poggi, D.O., Ltd. to carry out their responsibilities in connection with my medical/health care treatment, in payment for health care services rendered to me and in activities related to health care operations.

Initials: _____

I understand that additional information on Dr. Alfred J. Poggi's privacy practices related to my medical records is available from the Alfred J. Poggi, D.O., Ltd. comprehensive Notice of Privacy Practices, a copy of which has been made available to me, and which I have read or do not wish to read, prior to signing this consent.

Initials: _____

I understand that changes in Alfred J. Poggi's privacy practices will result in modifications to the Notice of Privacy Practices and that up-to-date notices will be available at the reception desk of Alfred J. Poggi, D.O., Ltd. at 277 Neilan Road, Somerset, PA 15501.

Initials: _____

I understand that I may request Alfred J. Poggi, D.O., Ltd. to restrict how or to whom my medical records are used or disclosed, but that Alfred J. Poggi, D.O., Ltd. may refuse the restrictions I request. However, if Alfred J. Poggi, D.O., Ltd. agrees to the restrictions, it is bound to them when disclosing information in my medical records.

Initials: _____

I understand that I can revoke this consent at any time, by notifying Alfred J. Poggi, D.O., Ltd. in writing, but if I do, it won't have any effect on actions Alfred J. Poggi, D.O., Ltd., took before he received the notification.

Initials: _____

I understand that this consent applies to the use and disclosure of information for treatment, payment or operations purposes only and that Alfred J. Poggi, D.O., Ltd. may decline to provide medical/health care services to me if I do not sign it.

Initials: _____

_____ _____

Signature of Patient or
Patient's Representative

Date

Printed Name of Patient's Representative _____

Relationship to Patient _____

Alfred J. Poggi, D.O., Ltd.

This Notice of Privacy Practices ("Notice") describes how medical information about you may be used and disclosed, and how you can get access to this information.

Please review this information carefully.

The law requires that we protect the privacy of your Protected Health Information (PHI) and that we give you a Notice of our legal duties and privacy practices with respect to PHI. PHI contains information that may identify your past, present or future physical or mental health conditions or healthcare services. This Notice explains how we can use or disclose the PHI in course of providing treatment, collecting payment and managing healthcare operations, and for other specific purposes permitted or required by law.

Protected Health Information includes:
- Information we place in your medical record
- Conversations your doctor has about your care or treatment with nurses and others
- Information about your health and healthcare in our computer systems
- Billing information about you at our practice

The Notice also explains your health information privacy rights.
The privacy practices described in this Notice will be followed by our entire workforce (employees, volunteers and contractors). We will not use or disclose your PHI without your written authorization, except as described in this Notice.

Your Health Information Privacy Rights

You have the right to:

1. **Receive the Notice of our Privacy Policies (this Notice) that tells you how your health information may be used and shared.** In most cases, this Notice should be made available to you on your first visit, and you can ask for a copy of it at any time.
2. **Inspect and obtain a copy of your health records.** You can ask to see and get a copy of your PHI. You may be charged a fee for the cost of copying and mailing necessary to fulfill your request. We may deny your request to inspect and obtain a copy of your PHI in certain limited circumstance. For example, if your doctor decides something in your file might endanger you or someone else, the doctor may not give this information to you. You have the right to appeal the denial.
3. **Amend your health information.** You may request that we amend any incorrect or incomplete PHI that we maintain about you. For example, if we both agree that your file has the wrong test result, we will change it. In certain cases, we may deny your request for amendment. If we deny your request for amendment you have the right to disagree with our decision.
4. **Authorize disclosure of your PHI.** In general, your health information including psychotherapy notes will not be given to your employer, used or shared for things like sales calls or advertising, or used or shared for many other purposes unless you give your permission by signing an authorization form.
5. **Request a report on how we disclosed your health information.** Under the law, your health information ma sure we give good care, y be used and shared for particular reasons, like making reporting when the flu is in your area, or making required reports to the police, such as reporting gunshot wounds. You can request a list of all non-authorized disclosures and who your health information has been shared with.
6. **Request to be contacted at different address or in a different way than we contact you now.** You have the right to ask us to contact you about your PHI at a different address or in a different way than we contact you now. For example, you can have the nurse call you at your office instead of your home. These requests are often made when a person feels his or her health or safety is in danger if PHI is sent to his or her home address. We will do our best to accommodate all reasonable requests.
7. **Request restrictions on certain use or disclosure of PHI.** You can request additional restrictions on the use or disclosure of your PHI. However, we are not required to agree with your request for additional restrictions.
8. **Request a restriction on disclosure of PHI to a health plan** with respect to health care for which you are paying out of pocket in full (or in other words, you have requested that we not bill your health plan). You have to make this request before services are provided.
9. **Ask for additional information or file complaints.** If you believe your health information was used or shared in a way that is not allowed under the privacy law, or if you were not able to exercise your rights, you can file a complaint with us or with the U.S. Government. This Notice tells you who to talk to and how to file a complaint.
10. **You have the right to opt out of our fundraising communications** if we engage in those.
11. **You have the right to be notified about data breaches** of your unsecured PHI.

We ask that you **exercise your rights in writing.** We offer forms and templates to help you exercise your privacy rights and to help us protect your health

Reasons and Examples of How We May Use or Disclose Your PHI

- Treatment - so you can get medical care. For example, we may share your medical information with your other doctor or pharmacy so that they can give you medical care and the right medicine. We may also call or write to provide refill reminders, to tell you about treatment options or other health-related services. We will not disclose PHI without authorization for marketing purposes.
- Payments - so we can determine plan coverage, billing/collection, and assist another health care provider with payment activities or recover payment from medical insurance. For example, the information accompanying the bill or insurance verification request may identify you as well as your treatment.
- Operations - so we can perform our duties. For example, we may use or share your medical information to assess quality of care, conduct training or to manage your care. We may also disclose PHI to an oversight agency in course of audits, complaint investigations and inspections necessary for our licensure, to satisfy government monitoring activities and regulatory compliance.
- There are some services provided by us through contracts with Business Associates, for example billing, scheduling or transcription services. When these services require access to your PHI we will disclose only minimum necessary information, so the contractors may perform their job. To protect your PHI we require Business Associates to safeguard PHI appropriately.
- To comply with the law. We may share your medical information to comply with legal proceedings, or in response to valid court or administrative order or subpoena.

For other reasons. Examples include:

- We may disclose PHI to support law enforcement (e.g. government authority such as police, social services) to protect someone's health and safety (e.g. victims of abuse, domestic violence);
- We will use our professional judgment and may share information with a family member, friend or other relative to help you obtain or pay for your health care;
- We may share PHI to notify a family member, relative, personal representative or other person responsible for your care about your general condition and location;
- So a personal representative you appoint or a court appoints for you can help you get health benefits;
- To support research as long as the privacy and security of PHI is ensured;
- So a coroner or medical examiner can identify a deceased person or cause of death or so a funeral director can arrange burial;
- To support, in limited circumstances an organ procurement organization;
- To protect you against a serious threat to your health or safety, or the health or safety of others;
- To support a government agency overseeing health care programs. For example, we may disclose your PHI to Food and Drug Administration (FDA) to enable investigations, drug/product recalls or replacements;
- We may disclose your PHI as authorized or necessary to comply with worker's compensation laws or other similar programs;
- For lawful national security purposes including intelligence or national security activities;
- For public health purposes to prevent or control disease; and
- For military purposes, if you are a member of the armed forces.

We will obtain your written authorization before using or disclosing your PHI for purposes other than those described in this Notice or as otherwise permitted by law e.g. marketing, sale of PHI. You will be able to revoke this authorization at any time.

Changes to this Notice

We reserve the right to change this Notice and to make the revised Notice effective for all health information we create or maintain. Upon request we will make the revised Notices available to you. The revised Notices will be posted and available at our office located at 277 Neilan Road, Somerset, PA 15501.

For More Information or to Report a Problem

If you have questions and would like to obtain additional information about our privacy practices, please contact our Privacy Officer at 814-443-3637, 277 Neilan Road, Somerset, PA 15501. If you believe your privacy rights have been violated, you may file a complaint with our Privacy Official at 814-443-3637, 277 Neilan Road, Somerset, PA 15501; or with the Office for Civil Rights, U.S. Department of Health and Human Services. You will not be retaliated against for filing a complaint.

This Notice of Privacy Practices is effective as of September 23, 2003

The Notice of Privacy Practices was last revised on 09/17/2013

Alfred J. Poggi, D.O., Ltd.
277 Neilan Road
Somerset, PA 15501
Phone: 814-443-3637

Acknowledgement of Receipt of Notice and Consent

To use and disclose Health Information

Read before signing

This acknowledgement of notice and consent authorizes Alfred J. Poggi, D.O. to use and disclose health information about you for treatment, payment, and health care operations purposes.

Alfred J. Poggi, D.O. has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgement and consent.

We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by request at our Office.

How to contact our Privacy Officer:

Mail: Dr. Alfred J. Poggi, 277 Neilan Road, Somerset, PA 15501
Telephone: 814-443-3637
Fax: 814-445-9330

Alfred J. Poggi, D.O., Ltd.
277 Neilan Road
Somerset, PA 15501
Phone: 814-443-3637

Acknowledgement and Consent

I have received the Notice of Privacy Practices for Alfred J. Poggi, D.O. and authorize his office to use and disclose health information about _____(Patient name) for treatment, payment, and healthcare operations purposes consistent with its Notice of Privacy Practices.

_____ _____
Signature of Patient Date

Personal representative information (if applicable)

_____
Name of Personal Representative and relationship to Patient

_____
Signature of Patient's personal representative

Acknowledgement of receipt of the Notice

I acknowledge that I received the Notice of Privacy Practices for Alfred J. Poggi, D.O.

_____
Name of Patient

_____
Signature of Patient or Patient's personal representative

_____
Date of receipt

Patient Information Release

To protect your privacy and confidentiality, and the confidentiality of your medical record, this office requires a signed permission in order to release any pertinent medical information about your over the phone or to release your medical records to anyone other than you. This includes but is not limited to labs, X-rays, test results, appointment schedules, physician request for information, insurance and personal information.

Name:_____

I do not want my information released to anyone. (I can ask to change this at a later date)

Signature:_____ Date: _____

I do want my information or medical record released to another person.

Designee Name: _____ Relationship: _____

Patient Signature: _____ Date: _____