1240 Environ Way * Chapel Hill, NC 27517
Phone: (919)240-7269 * Fax: (919)240-7816

HIPAA- PRIVACY CONSENT FORM

For Use of Disclosure of Private Health Information

- Trust is the foundation of a doctor/patient relationship.
- The information that you provide us will be kept in the strictest of confidence.
- While protecting your privacy is extremely important to us, there may be certain situations that may require us to use or disclose your healthcare information:
- It may be necessary to use or disclose your private health information to another healthcare provider or hospital when referred to them for the diagnosis, assessment or treatment of your health.
- It may be necessary to use or disclose your private health information and billing records to another party if they are responsible for the payment of your services.
- It may be necessary to use or disclose your private health information within our practice for quality control and operational purposes.

Authorization for Appointment Reminders and Health Care Information

We will be using your health insurance information for payment. A claim may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures performed and/or supplies used.

There may be times when the doctor or the staff of Mosaic Comprehensive Care may need to use your private health information (such as your name, address and phone number) in order to contact you with regard to appointment reminders, requested information about alternative treatment, or other health related information. If you are not at home to receive this information, please check one of the following:

☐ Okay to leave a message ☐ Not okay to leave a message

How would you like to be contacted for appointment reminders?:

☐ Home phone ☐ Cell phone ☐ Day phone ☐ Text message ☐ Home phone and text
☐ Cell phone and text ☐ Day phone and text ☐ Email ☐ None

I have read this consent form and agree to its term. I also acknowledge that once I sign this consent form, at my request, I will receive a copy for my record.

______________________________	______________________________
PATIENT PRINT NAME	**WITNESS**
______________________________	______________________________
PATIENT SIGNATURE	**DATE**

If you would like to have your personal health information disclosed to anyone other than yourself, please fill in the following information.

______________________________	______________________________
ADDITIONAL CONTACT(S)	**ADDITIONAL CONTACT(S)**

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Receipt of Practice Policies

I have received and understand the Mosaic Comprehensive Care Patient Policies. ______
Initials

I have received and understand the Mosaic Comprehensive Care Financial Policy. ______
Initials

____

Name Date

____

Signature

Newsletter

Please add your email address if you would like to sign up for our monthly newsletter!

Email Address: ____

Financial Guarantor

If someone else is financially responsible for you, please list them below along with their phone number.

___________________________________ ___________________________________

Name Phone Number

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Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name & Address____

____

I have received a copy of the Notice of Privacy Practices for Mosaic Comprehensive Care.

______________________________ ________________________

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ☐ An emergency existed & a signature was not possible at the time
- ☐ The individual refused to sign
- ☐ A copy was mailed with a request for a signature by return mail
- ☐ Unable to communicate with the patient for the following reason:
  ____
- ☐ Other:____

Prepared By:____

Signature:____

Date:____