Robert P. Binder D.P.M. Podiatric Medicine & Foot Surgery
9LFWRU0 YG6LWH5HVHGD&
Phone: (818) 349-8637 Fax: (818) 349-8306
www.feetbiz.com

Summary of Notice of Privacy Practice

This summary is provided to help you understand the Notice of Privacy Practices and describes how medic al information about you may be used and disclosed and how you can get access to this information.

Please review this notice carefully, the privacy of your medical information is important to us.

OUR LEGAL DUTY: We are required by applicable federal and state laws to maintain the privacy of your protected health information. We are also required to give your this notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow pthe privacy practices that are described in this notice while it is in effect. This notice takes effect 12/01/2018, and will remain in effect until we replace it. Copies of our complete notice of privacy practices, which contains a detailed description of how our office will protect your health care information, are located in the reception area and each treatment room. You may request a copy of our notice at any time.

USES AND DISCLOSURES OF HEALTH INFORMATION: We will use and disclose your health information in order to treat you or to assist other healthcare 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 healthcare providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training.

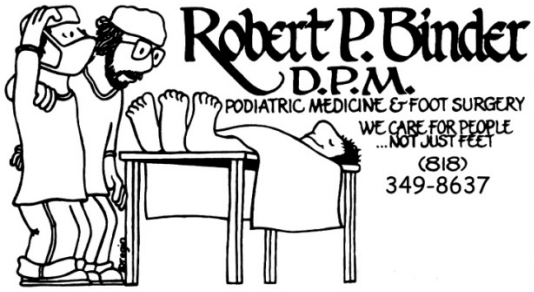
USES AND DISCLOSURES BASED ON YOUR AUTHORIZATION: Except as stated in more detail in the notice of privacy practices, we will not use or disclose your health information without your written authorization.

USES AND DISCLOSURES NOT REQUIRING YOUR AUTHORIZATION: In the following circumstances, we may disclose protected health or financial information without your written authorization:

To family members or close friends who are involved in your health. 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 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.

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 any questions, concerns or complaints regarding our privacy practices, please refer to our detailed Notice of Privacy Practices or contact a staff member.



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Summary of Notice of Privacy Practice (continued)

Patient Name (please print): _____ Date of Birth: _____

** All signatures below are the patient's unless the patient is unable to understand or sign. If a legally authorized representative is signing for the patient, please also print name and state relationship.
By signing each section you are stating you fully understand and agree to that section of this document.

Acknowledgement of Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices for Robert P. Binder D.P.M. Podiatric Medicine & Foot Surgery prior to my signing this, and that I have read or had the opportunity to read if I so choose and understand the notice.
Patient Signature: _____ **Date:** _____

Consent for Medical and Billing Records Access

I allow (Patient Designee) _____ (relationship) _____
To have access to my medical records.
Patient Signature: _____ **Date**: _____

Financial Policy

An insurance policy is an agreement between you and your insurance company. Payment for services rendered and reimbursement from the insurer is ultimately the responsibility of the patient. If your insurance company requires a referral, it is your responsibility to obtain the necessary referrals for each visit. If we do not participate in your plan, payment is expected when services are rendered. Copays, deductibles, and charges for non-covered services are due at time of visit. Interest may be added to past due accounts in the amount of 1.5% monthly. If your account is sent out for collection, you will be responsible for any additional collection costs and attorney fees that may be incurred, including past due interest charges and a late payment service charge.
Patient Signature: _____ **Date**: _____

Medicare & Commercial Insurance Assignment of Benefits

I request that payment of authorize Medicare/Commercial benefits be made directly to me or on my behalf of Robert P. Binder D.P.M. Podiatric Medicine & Foot Surgery for any services or products furnished me by him. I authorize any holder of medical information about me to release to the Health Care Financing Administration and it's agents any information needed to determine these benefits, or the benefits payable for related services.
Patient's Signature: _____ **Date:** _____