

COLUMBUS CLINIC
PATIENT ACKNOWLEDGEMENT FORM
Patient Acknowledgment of Understanding The Columbus Clinic's Privacy Practices

Patient Name: _____ **Date of Birth:** _____

SSN: _____ **Previous Name:** _____

I understand the patient's health information is private and confidential. I understand that The Columbus Clinic works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that The Columbus Clinic may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. **Our practice may contact you and remind you of an appointment and we may call to inform you of diagnostic test results. This includes leaving a message on voice mail.**

My signature below indicates that I have been given a copy of the current copy of The Columbus Clinic's "Notice of Privacy". Within this Notice of Privacy Practices is contained a complete description of my privacy/confidentiality rights. These rights include, but aren't limited to, access to my medical records, restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communication be by specified methods of communications or alternative location.

The Columbus Clinic has established procedures which help them meet their obligations to patients. These procedures may include other signature requirements, written acknowledgments, and authorizations; reasonable time frames for requesting information; charges for copies, etc. I will assist The Columbus Clinic by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices".

GUARANTOR OF FINANCIAL RESPONSIBILITY

Every patient is responsible for knowing the specific requirements of their insurance companies. With so many different insurance plans, it is unrealistic for our staff to know the specific requirements for all policies. Please let us know if you are required to have or use one of the following:

1. **Non Covered Services** - Any services performed that **are NOT COVERED** by your insurance company will be the patient's responsibility.
2. **A written referral from your Primary Care Physician (PCP).**
3. **A particular hospital.** Some insurance companies require use of a specific hospital.
4. **A particular laboratory.** Some insurance companies require use of a specific lab. If an outside laboratory is required by your insurance, you will receive a bill from the lab.
5. **Pre- Certification requirement** for outpatient surgeries or inpatient hospitalization. Also, a referral from your PCP is sometimes required.

If you are unsure about your insurance requirements, please contact you employer's personnel office/human resources representative at work or your insurance agent prior to your appt.

I have read the above and been given a copy of the Notice of Privacy Practice and I have read the Guarantor of Financial Responsibility. **I understand that it is my responsibility to make sure that all insurance requirements are fulfilled. It is also my responsibility to notify this office of any changes in my insurance. I agree to be responsible for all charges incurred with the Columbus Clinic that result from non-covered services or patient's failure to meet insurance requirements. I agree to pay any collection agency and/or attorney's fee to the Columbus Clinic should their services be required.**

Patient or legally authorized individual signature

Date

