AMHPI HIPAA RECERTIFICATION FORM

Date: _____

Patient Name: _____ DOB: _____

Financial Arrangements

Payment is due at the time of service. If billing is required and I do not pay the entire balance due within 25 days of the monthly billing date, a late charge of 1.5% on the unpaid balance will be assessed each month. I realize that failure to keep this account current may result in my being unable to receive additional services except for emergencies. In the case of default on payment of this account, I agree to pay all collection costs and reasonable attorney fees incurred in attempting to collect this amount or any future outstanding account balances. I agree to pay a $35.00 handling fee for all returned checks.

Failed Appointments

If I am unable to keep a scheduled appointment, I agree to call amhpi to notify them of my cancellation 24 hours prior to my appointment. If I do not call to cancel, I agree to pay a $35.00 failed appointment charge for each missed appointment.

Privacy Policy & Practices

Your privacy and the protection of your medical records from unauthorized disclosure is our commitment. No information is released without your consent.

Billing Services for amhpi are given your personal information to keep track of your account. This information includes your name, address, date of birth, insurance company, and other demographics. They also use dates of service, services provided, and diagnosis codes to provide information to authorize and pay claims sent to your insurance company.

Insurance for prescriptions and other claims require additional information before your prescriptions are filled. This includes previous mental health care, substance use and abuse history, psychiatric symptoms, prescribed medications, dates of service, and other medical/psychiatric information.

Other Health Professionals, with your written consent we provide copies of your medical records to and/or discuss your personal medical information with your primary care physician, other physicians, and/or your therapist. Although we recommend sharing this information to assist in the coordination of your care, we only do so with written permission from you. You can withdraw this permission at any time by notifying us in writing. Your permission lasts for one year and must be renewed annually.

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to other physicians in the case of emergency, third party payers for workmen's compensation claims, emergency legal matters, pharmacies, prescription insurance companies, managed care companies, and billing services. I agree that I am solely responsible for payment of this account, regardless of insurance coverage.

☐ Accepted or ☐ Declined <u>(PLEASE CHECK BOX)</u>

X_____

Signature of patient or parent if a minor Date

Last update: August 9, 2023