HOLTZMAN MEDICAL GROUP

1180 Beacon St, Suite 6B, Brookline MA 02446
(t) 781.770.4064 (f) 781.682.6157
www.holtzmanmedical.org

Notice of Assignment of Benefits, Release of Billing Information, and Medical History Authorization

Thank you for choosing Holtzman Medical Group, LLC. Please review the form below so we can provide the optimal care for you, bill appropriately, and share your information securely.

1. Consent for Treatment

By signing this form, you consent to and authorize Holtzman Medical Group, LLC, and its affiliates, to treat you. You understand this could include lab tests, x-rays, education, or other diagnostic tests. You understand that your provider is available to explain the treatment and you have the right to refuse treatment.

2. Professional Service Insurance Release & Assignment of Benefits

You authorize the release of any medical information necessary to process insurance claims for surgical and/or medical services provided to you or your dependents by Holtzman Medical Group, LLC and its affiliates. You also authorize payment of benefits directly to Holtzman Medical Group, LLC from any third party for services provided to your dependents or yourself. You understand that this authorization may not result in full payment by your insurance carrier for the charges incurred and agree that you are financially responsible to make payment in full on remaining patient balances should your insurance carrier determine the services you received are not covered.

3. Insurance

We participate in many insurance plans. If you are not insured by a plan we do business with, or do not have an up- to-date insurance card, payment in full is expected at each visit. When you provide us with current and complete information, we bill primary and secondary insurances. Please contact your insurance company with any questions you may have regarding your coverage.

4. Payment

You accept financial responsibility for payments for all services and products received. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. You may pay by cash, check, or credit card. There **may** be $25 processing fee if copay and/or deductible must be billed and is not paid at the time of service. You also understand there **will be** an additional $50 processing fee for collection

1180 Beacon St, Suite 6B, Brookline MA 02446
(t) 781.770.4064 (f) 781.682.6157
www.holtzmanmedical.org

accounts and bounced checks for each date of service.

5. Non-Covered Services

Please be aware that some of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. Payment for these services must be paid at the time of your visit. We will do our best to take reasonable steps to make you aware of these services prior to receiving them.

6. Patient Authorization

You authorize Holtzman Medical Group, LLC, and its affiliates, to send copies of your records to other physicians as needed for continuity of care. You understand that this is a group practice and other practitioners may be involved in your care. Unless there is an emergency, we will not send records prior to your authorization.

7. Authorization to Communicate Private Health Information

You authorize Holtzman Medical Group LLC to leave messages on my answering machine and/or voicemail, to send emails, and to send text messages unless specifically told otherwise.

Holtzman Medical Group utilizes electronic medical records (EMR) to store and transmit information. This includes the transmission and receipt of medical records from outside providers whom you may have seen in the past, are currently seeing, or may see after commencement of treatment at Holtzman Medical Group. You agree to allow Holtzman Medical Group to receive and import these records automatically for review, as deemed appropriate by the treating provider. This may include information of current or previous prescriptions from pharmacies. You agree to indemnify and hold harmless Holtzman Medical Group for any losses or damage as the result of receiving and reviewing medical records,

Holtzman Medical Group uses email as a means of communication. We will not use email to send protected health information unless you allow us to do so. You may notify us in writing, in person, or verbally that you wish us to transmit protected health information to you. In doing so, you acknowledge that email is not considered a secure means of communication and entails the risk that outside parties may obtain unauthorized access to information contained therein. At any time, you can request that we not send information via email, even if you have consented in the past to receive email communications. We offer a secure patient portal that you can use to send and receive information at any time. If you initiate a string of communication with us via email, you acknowledge that you wish that we respond via email unless or until we are told otherwise. Should you allow such communication, you agree to indemnify and hold harmless Holtzman Medical Group for any losses or damage as the result of sending protected health information over email.

HOLTZMAN MEDICAL GROUP

1180 Beacon St, Suite 6B, Brookline MA 02446
(t) 781.770.4064 (f) 781.682.6157
www.holtzmanmedical.org

Holtzman Medical Group, LLC will share private health information with family or others when we feel it is in the patient's best interest and the patient is unable, or lacks capacity, to consent in line with our current privacy practices.

8. Receipt of Office Policies

You agree that You have received and will abide by the office policies. You understand that the office policies might occasionally change and it is your responsibility to stay aware of any changes. Holtzman Medical Group, LLC, will do its best to make reasonable attempts to notify patients of material changes in office policies.

9. Patient's Right to Privacy

In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) we have our HIPAA Notice of Privacy Practices on display in the reception area and on our website. This document describes in detail how information about you, the patient, can be used within our office and with others who need to know reason for treatment, payment, and/or health care operations. If we were to disclose your information for any other reason, we would first need your written approval. A printed copy of the HIPAA notice will be provided upon request.

By signing below, you attest you have read the above and authorize Holtzman Medical Group, LLC, and its affiliates, to treat, bill and share you medical information as discussed above.

Signature of **Patient** (parent or guardian if minor)

X_____
_____

Patient
Name_____**Date**_____

Relationship to Patient_____**(for minor)**