Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of the uses and disclosures of my PHI. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.*

Print Patient Name or Legal Guardian: ____

Signature: ____ Date: __________________________________

REGIONAL HEALTH GROUP, INC. dba MUSCULOSKELETAL ASSOCIATES (MSA) / FINANCIAL POLICY

Thank you for choosing MSA as your health care provider. The following is our Financial Policy. If you have any questions or concerns about our payment policies please do not hesitate to ask our business office personnel. We ask that all patients read and sign our Financial Policy as well as complete our Patient Information Forms prior to seeing the doctor. Patient's portion of payment is due at the time services are rendered unless prior arrangements have been made with the business office manager.

We accept assignment with most major insurance companies and participating provider plans. However, you must understand that:

1. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance carrier.
2. All charges are your responsibility whether your insurance company pays or not.
3. Fees for services, along with unpaid deductibles and co-payments, are due at the time of treatment.
4. If the insurance company does not pay your balance in full within 30 days we ask that you contact the carrier to request prompt payment. Please inform our office of the carrier's response.
5. Returned checks will be subject to $30.00 collection charge. We will notify you by certified letter. If the check is not picked up within 10 days the check will be turned over to law enforcement.
6. Unpaid balances over 90 days are subject to collections via small claims court, attorney, and/or collection agency with applicable collection fees. Collection fees are the responsibility of the patient.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

Authorization to Release and Assign Insurance Benefits: I authorize release of any information required to act on any insurance claim and permit photographic or other facsimile reproduction of this authorization to be used in place of the original assignment. I hereby assign to MSA the medical and/or surgical benefits I am entitled from my insurance company and/or Medicare.

This authorization is in effect for all future claims, until I choose to revoke it in writing.

I, the undersigned, understand and agree to the above Financial Policy. I understand that I am financially responsible for all charges incurred for my medical treatment.

____	______________________________
Patient's Signature (Or Authorized Signature)	Date
____	______________________________
Printed Name of Patient	Relationship to patient if not patient

Witness Initials: ___________ (this is usually an MSA employee working at the front desk that can verify patient's signature)