Medical Weight Loss Specialists of Bismarck

Katie J. Horner, MSN, FNP-C

4503 Coleman Street, Suite 208
Bismarck, ND 58503

Phone: 701-354-0964
Fax: 701-354-0966
www.bismarckmedicalweightloss.com

Privacy Policy

HIPPA: THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

Uses and Disclosures of Information that We May Make Without Written Authorization: For treatment, payment, healthcare operations, as required by law, abuse or neglect, or communicable diseases, public health activities, health oversight activities, judicial and administrative proceedings, law enforcement, organ donation, research, workers compensation, appointments and services, marketing, business associates, military, inmates or person in police custody. **Uses and Disclosures of Information That We May Make Unless You Object:** We may use and disclose protected health information in the following instances without your written authorization unless you object:
If you object, please notify the Privacy Contact identified at the end of this document.

Persons Involved in Your Health Care: Unless you object, we may disclose protected health information to a member of your family, relative, close friend, or other person identified by you who is involved in your health care or the payment for your health care. We will limit the disclosure to the protected health information relevant to that person's involvement in your health care or payment. We may leave messages for you to call us or leave basic lab test results on your home phone unless you direct otherwise.

Notification: Unless you object, we may use or disclose protected health information to notify a family member or other person responsible for your care of your location and condition.

Person(s) Authorized to Receive Information _____

Physician Office(s) Authorized to Receive Medical Information_____

Your Rights Concerning Your Protected Health Information: You have the following rights concerning your protected health information. To exercise any of these rights, you must submit a written request to our Privacy Officer.

1. To request additional restrictions.
2. To receive communications by alternative means.
3. To inspect and copy records.
4. To request amendment to your record.
5. To request accounting of certain disclosures.
6. To receive a copy of our complete confidentiality notice.
7. To receive a copy of the bill to submit to your insurance. We will code your visit as medically correct as possible. Please note in rare instances a new diagnosis or prescription that you submit to your insurance may affect your insurability and or your insurance rates.

Complaints You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying our Privacy Officer. All complaints must be in writing. We will not retaliate against you for filing a complaint.

Entities to Whom This Notice Applies: This notice applies to Medical Weight Loss Specialists, the physicians, employees, and volunteers who work there. **Privacy Officer Contact**: If you have any questions about this notice, request a copy of the complete notice or if you want to object to or complain about any use of disclosure of exercise any right as explained above, please contact our Clinic Manager at Address: 4503 Coleman Street, Suite 208, Bismarck ND 58503. (701) 354-0964

I, the undersigned, have reviewed the information on this document, and have had an opportunity to ask questions and have them answered to my satisfaction. I understand that payment is due at time of service. Checks will not be held for deposit at a later date. I also understand that if payment is not made, I agree to pay any fees incurred while collecting payment along with a $25 fee for any returned check. Guarantor (myself) understands that I will be responsible for the balance and up to an additional 40% of the balance if the account is placed for collections with a third party agency. I understand that MWLS does not file medical insurance claims and cannot guarantee that insurance will reimburse for services provided.
I understand MWLS physicians have additionally opted out of Medicare payment benefits, thus Medicare may not reimburse for services provided here. You are responsible for notifying us if you receive Medicare for further required information. Please sign here to confirm your responsibility.

_____ _____

Patient Signature Date