TRIUMPH RADIOLOGY

352-554-4878
1-833-340-7254 (FAX)
3233 SW 33rd Rd Ste 301, Ocala, FL 34474
www.triumphradiology.com

FIRST NAME | MIDDLE INITIAL | LAST NAME | SUFFIX

DOB | GENDER | SSN | MARITAL STATUS

ADDRESS | CITY | STATE | ZIP

HOME PHONE | CELL PHONE | ALTERNATE PHONE

EMPLOYER | WORK PHONE

EMERGENCY CONTACT:_____ PHONE:_____

You are financially responsible for the services provided to you. As a courtesy to you, we file insurance on your behalf, if you provide us with complete and accurate insurance information. If you do not provide us with such information, we will bill you directly. When we file your claim, you are responsible for the difference between your account charges and payment received from your insurance company. You are responsible for payment of any deductibles or copayments. You are responsible for the entire balance if the insurance company denies payment. I hereby authorize payment to be made directly to Triumph Radiology, Ocala FL, for services rendered. I hereby authorize Triumph Radiology to release any information requested by the insurance company in order to pay this claim.

SIGNATURE OF PATIENT OR GUARDIAN | DATE

PRIMARY INSURANCE:

POLICY HOLDER
NAME:_____ DOB:_____

RELATIONSHIP TO PATIENT
(CIRCLE) SELF SPOUSE PARENT OTHER:_____

POLICY HOLDER SSN:_____ POLICYHOLDER
EMPLOYER:_____

SECONDARY INSURANCE:

POLICY HOLDER
NAME:_____ DOB:_____

RELATIONSHIP TO PATIENT
(CIRCLE) SELF SPOUSE PARENT OTHER:_____

POLICY HOLDER SSN:_____ POLICYHOLDER
EMPLOYER:_____

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

This notice of privacy practices describes how we may use and disclose your protected health information (PHI) to carry out any related care services, treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition.

1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related service. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. Another example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information may be used to obtain payment for your health care services. For example, this may include activities that a health insurance plan requires before it approves or pays for health care services such as: making a determination of eligibility or coverage, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

Healthcare Operations: We may use or disclose, as needed. Your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate the type of appointment you have. We may also call you by name in the waiting room. We may use your or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without authorization. These situations include: as required by law, public health issues required by law: communicable disease, health oversight, abuse or neglect, Food and Drug Administration requirements, Legal proceedings: law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity, national security inmates. Required uses and disclosures: under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of section 164.500. Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law in writing, except to the extent that your physician or the physician's practice has taken action in reliance on the use or disclosure indicated in the authorization.

Your Rights: The Following in a statement of your rights with respect to your protected health information.

HIPAA Notice of Privacy Practices, Continued.

You have the right to inspect and copy your protected health information: Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information: This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment, or healthcare operation. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare professional.

You have the right to request to receive confidential communications from use by alternative means or at an alternate location.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively ie: electronically.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint.

We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before August 2020. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA compliance officer in person or by phone (352) 554-4878

Signature below is only acknowledgement that you have received this notice of our privacy practices.

Print Name:_____ **Signature:**_____ **Date:**_____

AUTHORIZATION OF PROTECTED HEALTH INFORMATION RELEASE

Please PRINT the names of additional individuals you would like to be able to access your records

1._____ **2.**_____

3_____ **4.**_____

PATIENT INFORMATION **ACCT #**_____

_____

LAST NAME FIRST NAME

_____

DOB SSN

I HEREBY AUTHORIZE A PERMANENT TRANSFER OF MY MEDICAL RECORDS TO INCLUDE CD AND REPORTS.

X_____ _____

PATIENT SIGNATURE **DATE**

_____

TO BE COMPLETED BY OFFICE ONLY:

TO:_____

NAME OF FACILITY

_____

ADDRESS CITY/STATE

_____ _____

PHONE FAX

PLEASE SEND CD/REPORTS TO: **TRIUMPH RADIOLOGY**
3233 SW 33RD RD
SUITE 301
OCALA, FL 34474

**Florida law requires that information contained in medical records be held in strict confidence and cannot be released without your written authorization. The authorization you sign on this page will remain in effect until you notify our facility that you wish to withdraw this authorization, which you may do at any time. You have a right to receive a copy of this authorization upon your request