WESTERN MEDICAL ASSOCIATES, PC

PATIENT INTRODUCTION PACKET

Patient Agreement – READ CAREFULLY – VERY IMPORTANT

- Please read, sign and date at the bottom of the agreement and return to Western Medical Associates with the new patient paperwork.

Additional Patient Information / Medication Refill Policy

- Please read both sides and keep for your information.

CMS 1500 (Insurance Claim Form)

- Please read back of form and then sign and date boxes 12. and 13. on the front of the form. Fill in ONLY the darkly outlined boxes at the X's.

New Patient Paperwork

- *Patient Information Sheet* – Fill out completely with patient's information, sign and date. Patient will be asked to present insurance information at the first visit, so "see card" may be written in the insurance information blocks. Must have insurance cardholder's name, date of birth, social security number as well as address and phone number (if different from the patient).

- *HIPAA Notice of Privacy Practices* – Read, sign and date on back side of form.

- *Confidential Communication of Protected Health Information* – This form is designed to give Western Medical Associates permission to speak to someone besides the patient regarding his/her medical condition, prescriptions, test results and/or payment information. Please fill out, sign and date.

- If patient is coming from another physician or medical group, please fill out the *Medical Records Request* so that we can get the necessary records from that facility for the selected WMA provider.

Medication Refill Policy
Starting February 1st, 2008

1) Due to the large volume of patients and refill requests for chronic medical problems, we are changing our medication refill policy to improve the quality of care that we provide. Starting February 1, 2008, the providers at WMA will prescribe medications with enough refills to last until the next agreed upon appointment. This will prevent any delays with refills as well as help free-up medical staff and physicians to provide better and more timely care to our patients. It will be the patient's responsibility to schedule follow up appointments. We realize there will be a lag in implementing this policy, therefore, we will honor call-in and pharmacy request for refills (1 time only) to allow patients time to review our policy and to get their medication refilled until next appointment.

2) For acute medical problems, medications will not be called in without the patient being seen in the office. To improve accessibility to our office, we have started an Acute Care Clinic reserved for patients who need to be seen the same day. This clinic is for acute problems only. Chronic problems will be addressed with the patient's primary care provider on their regularly scheduled appointment.

3) Prescriptions for controlled substances (Schedule II, III, and IV) will be handled as follows.

Schedule II[1] medications – Due to the high risk and abuse potential of schedule II medications, prescriptions will be written for no more than 1 month at a time with a maximum of 2 refills. If granted, prescription refills can be picked up at the office during working hours, no more than three days before the original prescription expires. Follow-up appointment and refills will be agreed upon during your office visit.

Schedule III and IV[2] medications – Prescriptions will be written for no more than 3 months at a time. Refills may be granted up to 6 months if deemed appropriate by your provider. Refills and follow-up will be agreed upon during your office visit.

Schedule II[1] medications: fentanyl, hydrocodone, hydromorphine (Dilaudid), meperidine (Demerol), methamphetamine (Ritalin), morphine, oxycodone (OxyContin, Percocet), oxymorphine

Schedule III and IV[2] medications: butabarbital (Fiorinal), codeine, hydrocodone (Vicodin, Lortab), alprazolam (Xanax), chlordiazepoxide (Librium), clonazepam (Klonopin), Diazepam (Valium), dichloralphenazone (Midrin), flurazepam (Dalmane), lorazepam (Ativan), modafinil (Provigil), pentazocine (Talwin), sibutramine (Meridia), temazepam (Restoril), triazolam (Halcion), zaleplon (Sonata), Zolpidem (Ambien)

WESTERN MEDICAL ASSOCIATES
ADDITIONAL PATIENT GUIDELINES AND INFORMATION

- Provide the most current and complete information possible regarding your medical history and patient account. You will be asked to verify your personal information at each visit. We may ask to see your driver's license and insurance cards.

- As a courtesy, we will bill your insurance company; however, you will be expected to pay your copay or co-insurance payment at the time of service.

- Promptly pay your bills. If you cannot make payments on time, let our billing office know so we can work out a payment plan with you.

- Take care of medication prescriptions and paperwork (work releases, school excuses, etc.) during office visits. We no longer refill medications without the patient being seen in the office. See MEDICATION REFILL POLICY FOR DETAILS.

- Schedule follow-up appointments with your primary care provider in advance.

- Allow 24 hours for response to phone calls. Please allow that amount of time before placing another call or leaving another message. If message is urgent, please include that in your first message. Remember to correctly spell the patient's name and give birth date in order to facilitate your message.

- Allow 72 hours for labs, diagnostic results, prescription or sample requests, etc.

- Allow 10 working days for medical records requests.

- One of our providers will be conducting an acute care clinic each day. This will allow patients in our practice to be seen as quickly as possible when ill. This does not affect your relationship with your chosen provider.

- We provide an on-call physician to answer questions about medical urgencies or emergencies. The on-call physician will not call in prescriptions, approve refills, or schedule appointments after hours or over the weekend.

- We are pleased to announce that we now have a patient care coordinator to assist you with any questions or concerns about your visits to WMA. Erica Gardner, Director of Customer Care, will be glad to speak to you and help resolve any issues that you might have regarding your experiences at WMA. There are also Suggestion Boxes available to contribute your ideas for better service from us.

- Medical records requests can take up to 2 weeks. If that amount of time is not possible, please come to the office and sign a medical release with the date the records are needed. We will try our best to accommodate all requests as soon as possible.

See Back Page

WESTERN MEDICAL ASSOCIATES, P.C.

PATIENT INFORMATION

PLEASE FILL OUT COMPLETELY

Name ______ Last ______ First ______ Middle ______ Sex Male ☐ Female ☐

Mailing Address ______ City ______ State ______ Zip ______

Physical Address ______ City ______ State ______ Zip ______

Home Phone ( ) ______ Cellular ( ) ______

Date of Birth / / ______ S.S.N. - - ______

Marital Status (circle) Single Married Divorced Widowed Separated If Married - Spouse's Name ______

Employer ______ Work Phone ______

Employer Address ______

In Case of Emergency ______ Relationship ______ Phone ______

INSURANCE INFORMATION (PRIMARY - if applicable)

Insurance Company Name ______ Policy Number ______

Address ______ City ______ State ______ Group Number ______

Name of Insured (policy holder) ______

Social Security Number - - ______ Date of Birth / / ______

RESPONSIBLE PARTY (if different from patient)

Name ______ Relation to Patient ______

Address ______ Street / PO Box ______ City ______ State ______ Telephone ______

Social Security Number - - ______ Date of Birth / / ______

Employer ______ Work Telephone ______

Employer Address ______

INSURANCE INFORMATION (SECONDARY - if applicable)

Insurance Company Name ______ Policy Number ______

Address ______ City ______ State ______ Group Number ______

Name of Insured (policy holder) ______

Social Security Number - - ______ Date of Birth / / ______

05/20/2010

WESTERN MEDICAL ASSOCIATES, PC

6500 East Second St. Ste 200
Casper, WY 82609

Phone (307) 577-5100
Fax (307) 234-1201

Dear Patient;

Thank you for choosing Western Medical Associates for your health care needs. Our providers and the staff are dedicated to providing you the best care and customer service possible. In order to avoid some common misunderstandings, please take a few moments to read and sign the following Patient Agreement:

PATIENT AGREEMENT

_______________________________ (herein called the "patient") has entered into an AGREEMENT with Western Medical Associates (herein called "WMA").

- **New patient only** –**If a new patient does not show up for their first scheduled appointment and gives no notice, they will automatically be discharged from the practice.**
- I promise to call WMA at least 24 hours prior to my appointment if I need to cancel, so that another patient can be treated in my time slot.
- I promise to conduct myself in an orderly manner while at WMA (no swearing, angry outbursts, rudeness to WMA staff, etc) or I may be terminated from the practice.
- I understand that if I no-show an appointment, I may be charged a $25 no-call/no-show fee. I understand this is to be paid by me, personally, and will not be billed to my insurance company. I understand that I may be sent a warning letter after my second missed appointment without notification and upon my third no-call/no-show I may be discharged from the practice.
- It is my responsibility to be on time for my appointment. I understand that being more than 15 minutes late for an appointment may result in my appointment needing to be rescheduled. When you do not show up for your scheduled appointment, it hurts other patients who need to see our providers.
- I understand that I am a participant in my own health care, and that I am responsible for following my provider's healthcare plan for my own benefit.
- I understand that if I am a WMA patient who receives ongoing treatment/medication management, I need to have an appointment with my primary provider at least one time per year to renew medications as well as review and assess treatment. Failure to follow up as recommended could result in termination from the practice.
- I understand that I, the patient/guarantor, am responsible for full payment of any and all services rendered by WMA to me or my family members, including all services not covered by insurance. **WMA bills my private insurance as a courtesy and I, as the subscriber, am responsible for understanding the terms of my policy.** Any unpaid balance that has been billed to private insurance, after forty-five (45) days, is patient/guarantor responsibility. In the event of non-payment, I agree to pay all reasonable attorney fees and court costs if WMA refers my account to a third party collection agency.
- I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.
- I understand that as long as I participate and uphold my end of this Agreement, I am always welcome at WMA.

IN AGREEMENT THIS __________ DAY OF ________________________, 20______.
(day) (month) (year)

____
Patient Name (Print)

____
Authorized WMA Official

____
Patient/Guardian Signature

ANY CHANGES OR ADDITIONS TO THIS AGREEMENT ARE NOT PERMITTED

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

PICA

X 2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

Employed Full-Time Student Part-Time Student

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

X SIGNED X DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

X SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. ___ . ___

3. ___ . ___

2. ___ . ___

4. ___ . ___

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0999. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

CONFIDENTIAL COMMUNICATION OF PROTECTED HEALTH INFORMATION

Patient Name: ____

Information about my general medical condition, diagnosis as well as treatment, and payment information may be released to: (Please list name and phone number)

____

The following person(s) have my permission to make phone calls about my appointments or pick up my samples and/or prescriptions: (Please list name(s) – these persons may be asked to present ID)

____

ONLY IN AN EMERGENCY, please notify: (Please list name and phone number)

____

____

If other than your home address, please print the address where you would like your billing statement and/or correspondence sent:

____

CORRESPONDENCE FROM OUR OFFICE IS MAILED IN A SEALED ENVELOPE

Please list your home telephone number: ______________________________

Other than your home telephone number, where do you want to receive calls about your appointments, lab / x-ray / test results or other health care information?

Phone: ______________________ Place: ______________________

May we leave a message? ________ YES ________ NO

May we leave confidential messages at your place of employment? ________ YES ________ NO

Please list your work phone number: ______________________________

IT IS YOUR RESPONSIBILITY TO KEEP YOUR PHONE NUMBER AND ADDRESS INFORMATION UPDATED WITH US.

______________________________________ ______________________

Signature of Patient / Parent / or Guardian Date

HIPAA Notice of Privacy Practices

Western Medical Associates, PC
6500 E 2nd St., Ste. 200
Casper, WY 82609

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

This Notice of Privacy Practices is being provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). This Notice describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your right to access and control your health information in some cases. Your "protected health information" means any of your written and oral health information, including demographic data, which can be used to identify you. This is health information that is created or received by your health care provider, and relates to your past, present, or future physical or mental health or condition. This information may be stored in either a paper or electronic format, or both.

Uses and Disclosures of Protected Health Information (PHI)

Your PHI may be used or disclosed by your physician or other primary care provider (collectively referred to as "provider"), our office staff and others outside of 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 provider's practice, and any other use required by law.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. For example, your PHI 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 PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operation: We may use or disclose, as needed, your PHI in order to support the business activities of your provider'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 disclose your PHI to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you may be asked to sign your name and indicate your provider. We may also call you by name in the waiting room when your provider is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of an appointment.

We may use or disclose your PHI in the following situations without your authorization. These situations include: As required by law; Public health issues required by law, including communicable diseases; Health Oversight; Abuse or neglect; Food or Drug Administration requirements; Legal proceedings; To law enforcement; To Coroners, Funeral Directors and Organ Donation Programs; Research; Criminal Activity; Military Activity and National Security; Worker's Compensation; For inmates.

Other permitted and required uses and disclosures will be made upon receipt of your consent or authorization. You may revoke this authorization at any time, in writing, except to the extent that your provider or the provider's practice has taken action in reliance on the user or disclosure indicated in the authorization. Under the law, we must make disclosures to you upon request and when requested by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of 45 CFR § 164.500.

Your Rights

Following is a statement of you rights with respect to your protected health information (PHI).

You have the right to inspect and request copies of your PHI. 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 PHI that is subject to law that prohibits access to such PHI. To receive a copy of your records, a written authorization must be completed. You may request to receive in an electronic format any of your records that are stored and readily producible in an electronic format.

You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or health care operations. You may restrict the disclosure of your PHI to your health plan if services are paid for in full. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction and to whom you want the restriction applied. With exception of the aforementioned restriction to your health plan, your provider is not required to agree to a restriction that you may request. If the provider believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to choose another health care provider.

You have the right to request to receive confidential communications from us by alternative means or at an alternative 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, i.e. electronically.

You have the right to request to have your provider amend your PHI. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosure we have made, if any, of your PHI.

You will receive notification in the event of a breach that affects your unsecured PHI.

You have the right to complain to us or to 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 Officer in person, by phone, or by mail. **We will not retaliate against you for filing a complaint.**

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 Privacy Officer in person or by phone at our main phone number.

This notice was published and becomes effective on June 4, 2013.

Signature below is only acknowledgement that you have received this Notice of Privacy Practices:

Patient/Guardian Signature:____________________________________

Print Patient Name:____________________________ DOB:______________

Today's Date:__________________

PERMISSION TO TREAT MINOR CHILD

Date ____________________________

I, ____, parent/guardian of

____, minor child, give my
(PATIENT NAME)

permission for ____ to accompany

my child for examination and/or treatment at Western Medical Associates

this _____ day of __________________________, 20_____.

CHECK ONE

_______ This is permission for stated appointment date only

_______ This is permission for any appointments in the future

____

Parent/Guardian Signature

Western Medical Associates, PC.
6500 E 2nd St. Ste. 200 Casper, WY 82609
(307)577-5100 *phone* (307)234-1201 *fax*

Authorization for Disclosure of Protected Health Information

Patient Name:______________________________
Telephone #:______________________________
Date of Birth:______________________________
SSN#:______________________________

RELEASE FROM

____

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____

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***give complete information of where records are being requested from, including physician name, phone and fax number, and address if applicable. Failure to provide this information could result in a delay of processing.**

RELEASE TO

WESTERN MEDICAL ASSOC.
6500 E 2nd St. Ste. 200
Casper, WY 82609

(307)577-5100 *phone*
(307)234-1201 *fax*

Purpose of disclosure:____

Information to be disclosed:	**Dates(if applicable):**
Entire record__________	______________________
Lab reports__________	______________________
Radiology reports__________	______________________
Other (specify)______________________	______________________

Specific authorization to disclose sensitive records

I authorize the disclosure of these additionally protected records (please initial next to each):
Alcohol and/or substance abuse records__________
Mental Health records (depression/anxiety)__________
Other Mental Health/Psychiatric records__________
Sexually transmitted disease information__________
HIV/AIDS information__________
***Federal law prohibits the re-disclosure of this information without the express written permission of the person to whom it pertains.**

______________________________ (Signature)

______________________________ (Name Printed)

______________________________ (relation to patient/authority to act for patient)

______________________________ (Date)

*HIPAA allows 30 (thirty) days for a provider to respond to your request for records. Western Medical Associates medical records policy calls for a standard 2 (two) week turn around on all records requests. In certain instances, there may be applicable fees for copying records, including postage. This medical release form is valid for above stated medical records for 1 **(one)** year from signed date. Records **will not** be faxed to an unsecure fax line. I understand that I may revoke this authorization in writing at any time prior to Western Medical Associates, PC, acting upon the authorization. I understand that Western Medical Associates, PC, may not base treatment or payment upon completion of this form. I understand that disclosed information may be subject to re-disclosure by the recipient and may no longer be protected by federal law, if the recipient is not a "covered entity."