GEORGE R. GOTTLIEB, M.D., P.C.
ASTHMA AND DISEASES OF ALLERGY

PATIENT NAME ____ DOB_________________

PHONE # ___________________ WORK # ____________________ CELL # _______________

ADDRESS ____

INSURANCE POLICY

- It is **your responsibility** to be aware of your individual insurance coverage and what might be covered or non-covered services. Your co-pay, co-insurance or deductible is expected at time of service in accordance with your insurance policy. If r**eferral** is required, it is your responsibility to obtain this from your **primary care physician** before your visit.
- Although we will contact your insurance company concerning your coverage and co-pays, **we cannot guarantee your payment liability until claim has been finalized by your insurance company, according to your plan**.
- We must have your **most current** insurance card. This enables our office to file your insurance. If your card is not **current, you will be responsible** for payment of all charges before leaving the office.

In General, the HIPAA Privacy Rule gives individuals the right to request a restriction of their health information. The individual is also provided the right to request confidential communications or that a communication of 'PHI' (Protected Health Information) be made by alternative means, such as sending information to the individual's office instead of their home.

You can specify how to communicate your Protected Health Information (PHI). (CHECK all that apply):

HOME TELEPHONE NUMBER: ________________
OKAY TO LEAVE MESSAGE WITH DETAILS ____________, OR ONLY CALL BACK PHONE #___________. **OKAY TO SPEAK TO SPOUSE _________ OTHER ___________**

WORK TELEPHONE NUMBER: ______________
OKAY TO LEAVE MESSAGE WITH DETAILS ______________, OR WITH ONLY CALL BACK PHONE #______________

WRITTEN COMMUNICATION: TO MY HOME ____________, TO MY WORK ____________ or

I GIVE DR. GOTTLIEB AND STAFF PERMISSION TO USE AND DISCLOSE 'PHI' AS NECESSARY TO CARRY OUT (TREATMENT OR PAYMENT).

BY SIGNING THIS FORM, I UNDERSTAND THAT THE PRIVACY PRACTICES OF THE OFFICE HAVE BEEN DISCLOSED TO ME. THIS INFORMATION WILL STAY ON RECORD FOR 6-YEARS.

I HAVE READ AND UNDERSTAND ABOVE INFORMATION

SIGNED: ____ **DATE:** __________________