Insurance Assignment of Benefits Policy:

1. It is my responsibility to provide Nashville Medical and Genetics with my current insurance. If my insurance changes at any time during my treatment at Nashville Medical and Genetics, I understand that it is my responsibility to provide them with this updated information.
2. If Nashville Medical and Genetics accepts assignment for my insurance, I hereby authorize direct payment and surgical/medical benefits to practitioners of Nashville Medical and Genetics for services rendered and understand that I am financially responsible for any balances waived or not covered by my insurance.
3. I hereby authorize the practitioners of Nashville Medical and Genetics to release any medical or incidental information that may be necessary for either medical care of treatment to my insurance company for payment of benefits towards my services.
4. I certify that the information given to me in applying payment is correct. I authorize release of all records on request. I request that payment of authorized payments benefits be made on my behalf to Nashville Medical and Genetics. A photocopy of these assignments shall be valid as the originals.
5. This office will make a reasonable attempt to resolve your denied insurance claim or dispute its settlement. However, it is ultimately your responsibility to contact your insurance company for resolution if the clinic's attempts are unsuccessful. If you choose not to resolve the issue with your insurance company then you are responsible for payment of these services as allowable by your insurance.

Payment Policy:

1. I understand co-payments will be collected at time of my office visit. For your convenience we accept MasterCard, Visa, Discover, cash and checks.
2. Returned checks will be charged a $30.00 fee.

Collections Policy:

1. I understand that all balances are due upon receiving my statement from Nashville Medical and Genetics. Balances that exceed ***90 days without payment will be turned over to an outside Collection Agency.***
2. I understand that it is my responsibility to contact Nashville Medical and Genetics regarding any issues with my account. It is my responsibility to make Nashville Medical and Genetics aware of any financial hardships so that payment arrangements can be set up for my account.
3. ***I understand that if my account is turned over to the outside Collection Agency there will be a 30% increase to my balance.***

Patient Portal:

1. I confirm that I have received my username and password to gain access to Nashville Medical and Genetics secure patient portal.

I acknowledge that I have read the policies listed above and understand my role in the assignment of insurance benefits, payment, collections and patient portal polices of Nashville Medical and Genetics.

____________________________________ __________________________

Patient Signature **Date**

____________________________________ __________________________

Witness Signature **Date**

Nashville Medical and Genetics

Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 (“HIPPA”), 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 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.

How may we contact you regarding appointments?

Email: _______________________________

Phone: ______________________________

Patient Name or Legal Guardian: ____

Signature: ____

Date: ______________________

PRACTICE USE ONLY

I attempted to obtain the patient’s signature in acknowledgement of the NOTICE of

PRIVACY PRACTICES ACKNOWLEDGEMENT but was unable to do so as documented below:

Date:_____________ Initials:_______ Reason:____________________

Patient Portal Instructions

On behalf on Nashville Medical and Genetics thank you for filling out your medical history and checking in for your appointment prior to coming in.

You can go to www.yourhealthfile.com to access your patient records. Nashville Medical and Genetics staff will provide your username and password.

Step by Step Instructions

- Enter username and password. Select “Activate Account”
- Accept licensure agreement
- E-sign and Initial all documents
- Select Medical Records tab which will direct you to where information can be entered
  - *Allergies
  - *Medical history to include: Your medical and surgical history along with family history
  - *Medications
  - *Social history
- Please then go to the Appointment tab and check yourself in for your appointment (this can be done a day or two prior)
- Confirm your demographics and insurance
- Please answer the Review of Symptoms page as well. If you have NO current medical history problems you can select “Mark all normal” on this page.

Upon completing the Review of Symptoms page you are DONE and have COMPLETED your health portal.

*If at anytime you have questions please call Nashville Medical and Genetics office and the staff will be available to answer your questions. Phone number 615-462-5171