

Patient Name: _____

DOB: _____

Acct #: _____

**Patient Authorization for Practice to Release
Protected Health Information to Third Parties**

By signing this authorization, I authorize CopperView Medical Center to use and/or disclose demographic, insurance and/or billing information (including diagnosis and procedure codes and descriptions) medical records, clinical notes, lab results, imaging results, referral information, etc about me to or for the party or parties listed below.

This authorization permits CopperView Medical Center to use or disclose to the following list of people(s).....

_____	__/__/__	_____	__/__/__
Name	Date of Birth	Name	Date of Birth
_____		_____	
Relationship		Relationship	

This authorization will expire on _____ (Expiration Date or Defined Event)
When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that CopperView Medical Center has acted in reliance upon this authorization. My written revocation must be submitted to CopperView Medical Center's Privacy Officer.

Signed by: _____ (Date) _____
 _____ (Signature of Patient or Legal Guardian)

 Print Name of Patient or Legal Gaurdian

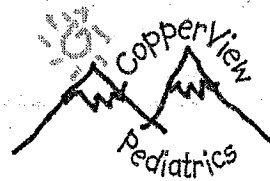
Prescription Release

I authorize CopperView Medical Center to release any and all prescription(s) written to myself or my dependent to the following individual(s). Prescriptions may be written under any provider practicing at CopperView Medical Center; including but not limited to controlled substances.

Name: _____	Name: _____
Date of Birth: _____	Date of Birth: _____
Phone #: _____	Phone #: _____



CopperView Medical Center



FINANCIAL POLICY AND AGREEMENT

Thank you for choosing CopperView Medical Center as your healthcare provider. We are committed to excellent patient care. The following is an explanation of our financial policy and agreement, which you must read and sign prior to any medical evaluation or treatment.

1. Each patient is responsible for his or her own bill.
2. Payment of all insurance co-payments and deductibles is required at the time of service. What your insurance does not cover and you are responsible to pay, is a contract between you and your insurance company.
3. Patients who have no insurance are required to pay 100% of services rendered at each visit. If this is not possible, you will need to make payment arrangements with our billing office. We accept; cash, Visa/MasterCard, American Express, and Discover/Novus.
4. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy, this office will submit bills to your insurance carrier. In order to facilitate claims processing, you must provide all insurance policy information and changes to our office. Your bill is your responsibility whether your insurance company pays or not. At times, you may need to contact your insurance carrier regarding slow or non-payment of your insurance claim.
5. You are responsible for knowing what your insurance covers and the providers and network(s) covered under your health insurance plan. Any service provided, but not covered by your insurance company, will be your responsibility to pay.
6. You are responsible for any laboratory service performed at these facilities that are sent out to a third party laboratory for processing. All billing for laboratory services are generated through the lab itself; we do however provide your insurance information to the lab for billing purposes only.
7. If for any reason, should collection become necessary, the responsible party agrees to pay an additional 40% collection fee of any charges being sent to the collection agency, and all legal fees of collection with or without suit including attorney fees and court fees.
8. Be aware that we may charge a \$25.00 fee for no-showed appointments.
9. Be aware for any inadequate cancellation; defined as one hour or less of your appointment time, may be charged a \$25.00 fee.

Usual and Customary Rates

Our rates for medical services reflect the usual and customary rates in the community.

Authorization to Pay Benefits

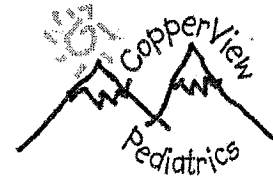
I further authorize and direct said agency, attorney or insurance company to pay from the proceeds of benefits of any recovery or insurance payments in my case, directly to the providers of this office, for their professional services rendered. I understand that this in no way relieves me of my personal responsibility for payment to my provider when a statement is rendered.

Signature of patient or responsible party

Date



CopperView Medical Center



Date: _____

I, _____, a parent, or legal guardian of:
(please print)

List Child(ren)/Patient Name(s):

Account Number:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

was made aware that there is a copy of the CopperView Medical Center Notice of HIPAA Privacy Practice, located in the waiting are. If I desire to obtain a copy of the Privacy Practice Pamphlet, one can be obtained from the receptionist desk. I have been informed that should I have questions regarding this Privacy Policy or do not understand the information in the Notice that I may direct these questions to the Privacy Officer.

Patient or Guardian Signature

Date

FOR YOUR INFORMATION:

Dr. Hollingsworth, MD and Dr. Lei, MD are proud owners of Jordan Valley Medical Center, a physician-owned hospital under 42 U.S.C. §1395nn. At the time of a referral for any necessary hospital services, each of our patients may choose Jordan Valley Medical Center or any other facility, center or hospital for the purpose of having such services performed as determined by the patient to be in the patient's best interest.