CORNERSTONE FAMILY PRACTICE
NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996, (HIPPA), I have certain rights to privacy regarding my protected health information. 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 my treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and Physicians certifications.

Any other uses of my protected health information will require my written release.
I acknowledge by my signature below I have read and reviewed the complete Notice of Privacy Practices for Cornerstone Family Practice.
I wish to receive a copy of the Notice of Privacy Practices. Yes_____ No_____
To help us serve you better please check the appropriate boxes.
Family Members:
_____ I give Cornerstone Family Practice physicians and staff permission to speak to a family member about my treatment or care.
_____ I do NOT give Cornerstone Family Practice physicians or staff to speak to a family member about my treatment or care without my written consent.
Home Telephone: Please check appropriate boxes
_____Leave message with call back number only
_____ OK to leave detailed message on home voice mail
_____ OK to leave message with another family member who answers the phone when I am not available.
Work Phone: Please check appropriate boxes
_____ OK to leave message with call back number only
_____ OK to leave detailed message on voice mail at work
Cell Phone: Please check appropriate boxes
_____ OK to leave message with call back number only
_____ OK to leave detailed message on cell phone voice mail

We will leave a confirmation message on your voice mail before your appointments.

I give permission for Cornerstone Family Practice physicians and/or staff to speak to:

_____Relationship_____
Phone #_____
In regards to my medical treatment and care.

Patient Name (Print)_____
Patient
Signature:_____Date_____

CORNERSTONE FAMILY PRACTICE OFFICE POLICY / HIPPA

Assignment of Benefits

I authorize payment of medical benefits to Cornerstone Family Practice, PC for professional services rendered.

Acknowledgement of Financial Responsibility

The patient and insurance information I provide is accurate and true to the best of my knowledge. I understand that I am ultimately responsible for services rendered. I understand that if I have an outstanding balance, it must be paid prior to my being seen again. If my balance owed exceeds 90 days, I will be sent to a collection agency and will no longer be seen at Cornerstone Family Practice.

No show/Cancellation Policy

I understand that I will be billed (not my insurance) a fee **$25.00** (Non Physical Appointment) and **$40.00** (all other appointments) for any no show or cancellation NOT made **24 business hours prior to my appointment time**. More than 3 consecutive "NO SHOWS" could result in dismissal from Cornerstone Family Practice.

Co Pay Policy

I acknowledge that I am responsible for paying my co pay amount to Cornerstone Family Practice, PC prior to any appointment. If I cannot comply, I understand that I will be rescheduled and I will be billed (not my insurance) a $10.00 fee for failure to pay.

CDC Guidelines

Cornerstone Family Practice follows the current CDC guidelines due to the current Pandemic of Corona Virus (COVID-19). It is our policy that ALL patients MUST wear a mask for the protection of others AND themselves. Anyone that refuses to wear a mask will be asked to reschedule their appointment.

Audio and Video Recording

Please be aware that you are NOT allowed to audio/video record ANY interaction in our office or over the phone without notification and consent from the person(s) being recorded according to Colorado Statute: Colo. Rev. Stat.§18-9-303

Notice of Privacy Practices – HIPPA

I acknowledge that I have been offered access to **Cornerstone Family Practice's** notice of Privacy Practices via the posted form in the waiting room or a hard copy provided by the receptionist at my request. I also understand that **Cornerstone Family Practice, PC** endorses, supports and participates in **Health Information Exchange (HIE)** as meant to improve the quality of your health and healthcare experience. **HIE** provides us with a new way to securely and efficiently share patient's clinical information electronically with other physicians and healthcare providers that participate in the **HIE** network. Using **HIE** helps your healthcare providers to more effectively share information and provide you with better care. The **HIE** also enables emergency medical personnel and others who are treating you to have immediate access to your medical data that may be critical for your care. Making your health information available to your healthcare providers through the **HIE** can also help reduce your costs by eliminating unnecessary duplication of tests and procedures. However, you may choose to opt out of participation in the **CORHIO HIE**, or cancel an opt-out choice, at any time

Consent to be contacted via email

I consent to be contacted via the email address that I have provided below.

Patient Signature_____Date_____
(or parent/guardian if patient is minor)

Please print patient's name_____

Email address:_____

CORNERSTONE FAMILY PRACTICE EMAIL CONSENT FORM

RISKS OF USING EMAIL

For the ease of our patients, our office offers the opportunity to communicate by email. Transmitting patient information poses several risks and the patient should not agree to communicate with the office via email without understanding and accepting these risks. The risks include, but are NOT limited to the following:

RISKS OF USING EMAIL

- The privacy and security of email communication cannot be guaranteed.
- Email senders can misaddress, resulting in the email being sent to unintended recipients.
- Employers/Online services may have a legal right to inspect and keep emails that pass through their system.
- Even after deletion of the email, back up copies may remain on a computer.
- Email is easier to falsify than signed hard copies. In addition, it is impossible to verify the true identity of the sender, or to ensure that only the recipient can read it.
- Emails can introduce viruses, generally damage or disrupt the computer.
- Email can be used as evidence in court.

CONDITIONS OF USING EMAIL

Our office will use reasonable means to protect the security and confidentiality of email information sent and received-however **we cannot guarantee the security of email communication. Thus, patients must consent to the use of email for patient information, billing and communication. Consent to use email includes agreement with the following conditions**:

- Emails to or from the patient concerning treatment may be printed and made a part of the patient's medical record. Because they are a part of the medical record, authorized individuals will have access to the record/email (e.g. billing staff)
- Our office may forward emails internally to those involved, as necessary, for healthcare operations and other handling. Our staff will NOT forward emails to independent third parties without the patient's prior written consent, except as authorized or required by law.
- Although our office will endeavor to read and respond promptly to all emails from patients, it is NOT a guarantee that any particular email will be read and responded to within any particular period of time. The patient should NOT use email for medical emergencies or other time sensitive matters.
- If the patient's email invites a response from office staff and a response is not received within a reasonable time period, it is the patient's responsibility to follow up.

Cornerstone Family Practice including staff, are NOT responsible for information loss due to technical failures associated with email software or internet service provider.

Patient Signature_____Date:_____