NORTH TEXAS GASTROINTESTINAL ASSOCIATES, DR. SHAWN W. PANZER, M.D.
2501 SCRIPTURE, BLDG 6, STE 201, DENTON, TX 76201
PH: (940)566-4720 FAX: (940)566-4727

NOTICE OF PRIVACY PRACTICES

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

Summary:
By law, we are required to provide you with our Notice of Privacy Practices (NPP).
This Notice describes how your medical information may be used and disclosed by us.
It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

1. **The right to inspect and copy your information**
2. **The right to request corrections to your information.**
3. **The right to request that your information be restricted**
4. **The right to request confidential communications**
5. **The right to a report of disclosure of your information; and**
6. **The right to a paper copy of this notice.**

We want to assure you that your medical/protected health information is secure with us. This Notice contains information about how we will insure that your information remains private. If you have any questions about this Notice, the name and phone number of our contact person is listed on this page.

Effective date of this notice	January 1, 2011
Phone Number	940-566-4720

Acknowledgment of Notice of Privacy Practices

"I hereby acknowledge that I have received a copy of this practice's NOTICE OF PRIVACY PRACTICES. I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed above. I further understand that the practice will offer me updates to this NOTICE OF PRIVACY PRACTICES should it be amended, modified, or changed in any way."

X___________________________________ **X _________________________________**
SIGNATURE OF PATIENT **PRINTED NAME OF PATIENT**

____
DATE

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Financial Responsibility:

To reduce confusion and any misunderstanding between our patients and this practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment. Unless other arrangements have been made in advance by either you or your health insurance carrier, we require full payment at the time of service. For your convenience we accept Visa, MasterCard, Discover, and American Express cards, cash or local check. All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Your insurance:

We have contracts with many major insurance carriers to accept an assignment of benefits. This means that we bill those plans for which we have an agreement and will require you to pay the authorized copayment at the time of service. This office's policy is to collect this copayment when you arrive for your appointment.

If you have insurance coverage with an insurance plan for which we do not have a contract with, we will send a claim for you on an unassigned basis. Consequently, you will have a higher than usual out of pocket expense and the charges for your care are due at the time of service.

In the event your health plan determines a service as "non-covered" you will be responsible for the complete charge. Payment is due upon receipt of statement from our office.

We will bill your health plan for all services provided in the hospital, whether done inpatient or outpatient. Any balance due is your responsibility and is due upon receipt of a statement from our office.

Minor Patients:

For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

Assignment of Benefits:

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to NORTH TEXAS GI ASSOCIATES for medical services rendered to me and/or my dependents regardless of my insurance benefits, if any, I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information:

I hereby authorize NORTH TEXAS GI ASSOCIATES to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment: and (3) allow a photocopy of my signature to be used to process insurance claims for the period of my lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from NORTH TEXAS GI ASSOCIATES on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this agreement is to be considered as valid as the original.

I have read and understand the financial policy for North Texas GI Associates, the office of Dr. Shawn Panzer, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms periodically.

X ______________________________ **X** __________________________________ **DATE:** __________________

SIGNATURE OF PATIENT **PRINTED NAME OF PATIENT**