

PIGA PRIMARY CARE ASSOCIATES

Specialists in Adult and Pediatric Medicine

Jonathan C Piga, MD
Naomi C Piga, MD FAAP
Versallie R Capote-Piga, MD FAAP



Notice of Privacy Practices (HIPAA)

*This notice describes how medical information about you may be used/disclosed and how you can get access to this information.
Please read it carefully.*

This office may use and disclose medical and financial information related to your care that may be necessary to facilitate payment by third parties for services rendered by us, or to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes for evaluation purposes. Such information may be released to insurance companies, HMO's and PPO's, managed care organizations, IPA's, Medicare/Medicaid, or other governmental or third party payors, or any organizations contracting with any of the above entities to perform such functions. Medical records may be delivered to a primary care physician or any other physician that is directly or indirectly responsible for your medical care or the payment thereof.

We are legally obligated to maintain the privacy of your protected health information and to provide you with this Notice of Privacy Practices and to abide by its terms. We reserve the right to change our privacy practices and apply revised privacy practices to protected health information.

The type and amount of information to be used or disclosed is as follows:

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

___ **All Health Care information.**

___ All Health Care Information **excluding** information relating to HIV/AIDS testing, sexually transmitted diseases, psychiatric disorders / mental health or drug and/or alcohol use.

Please circle your response to the following:

| | | | |
|---|-----|----|-----|
| May we leave messages concerning appointments with a co-worker, receptionist or secretary who regularly answer your calls? | Yes | No | N/A |
| May we leave messages on a voice mail at your home? | Yes | No | N/A |
| May we leave messages on a voice mail at work? | Yes | No | N/A |
| May we discuss appointments/treatment with other parent/guardian/caregiver/family members? | Yes | No | N/A |

Who? _____

For minor patients less than 17 years of age, all treatment and medical information will be discussed with both biological parents unless otherwise specified.

I understand that I have a right to revoke this authorization at any time. I understand that I need to inform the office, in writing, of any changes in my directives. I understand that this HIPAA notice will be kept in my file. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

8380 Warren Parkway Ste 305, Frisco, Texas 75034

(214) 618 2222

www.pigaprimarycare.com

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I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that without disclosure, I will be responsible for payment of services when they are rendered and will file my claims directly to my own insurance company. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

For Pediatric Patients:

I authorize the release of immunization records that have been requested verbally to schools/camps/daycares. I understand that there is a **\$2 fee** per request. _____ (initial here)

Name of patient: _____ Date of birth: _____

Signature of patient/legal representative: _____

Date: _____

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