ERIC R. SUE, M.D.

THE SUE MEDICAL GROUP – INTERNAL MEDICINE
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ATTENTION

DR. SUE ACCEPTS MEDICARE, AETNA, ANTHEM BLUE CROSS PPO AND UNITED HEALTHCARE PPO PLANS ONLY.

AETNA, ANTHEM BLUE CROSS AND UNITED HEALTHCARE MEMBERS

I acknowledge that Dr. Sue is NOT a provider for any Covered California, Affordable Care Act plans also known as “Obamacare” or EPO health plans. I understand that my insurance card is NOT confirmation of coverage, and regardless of what the card reads, I am financially responsible for all costs that are not covered by my primary insurance.

MEDICARE MEMBERS

I acknowledge that I am financially responsible for all costs after Medicare, secondary and tertiary insurance payments are received.

OUT-OF-NETWORK PATIENTS

I acknowledge that I am financially responsible for all costs rendered at the time of service, and that I am responsible for submitting my own claim to my insurance company.

☒ **I have read the above statements and accept these terms as stated.**

Initial: _______

Dr. Sue provides what he feels is the best and appropriate care for your health. However, some services may not be covered by your insurance company or plan. Your carrier may use the terms “medically necessary”, “routine”, “not covered” or “preventive care” to deny coverage for services including routine physicals, pre-operative clearance, injections/vaccines, HIV screening and others. Furthermore, carriers may claim to cover “routine care”, but this may not be as comprehensive as you expect.

The lack of consistency among the multitude of carriers makes it difficult to keep up with which carriers cover which services. Although we can help in corresponding with your carrier to appeal improperly denied claims, we cannot predict the outcome of claims review. We encourage you to contact your carrier prior to being seen to verify that coverage is available for expected services.

Your signature verifies that you understand that services provided may not be covered by your policy and that you are financially responsible for these services, even if deemed unnecessary or not payable by your carrier.

Patient Name: ___________________________________

Signature: _______________________________________   Date: ____________________

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about our patients may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (**HIPAA**).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities/health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment or healthcare operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Dr. Sue at (310) 556-1800 who will have up to 30 days to comply.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Dr. Sue at (310) 556-1800 who will have 60 days to respond. You must provide us with a legitimate reason that supports your request for amendment.
5. You are entitled to receive a copy of this Notice of Privacy Practices. At any time, you may obtain a copy of this notice by contacting our front desk receptionist.
6. If you believe your privacy rights have been violate, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint, contact Dr. Sue at (310) 556-1800. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact your physician.
I hereby acknowledge that I have been presented with a copy of this office's Notice of Privacy Practices.

Patient Name: ____ Date: __________________________

Patient Signature: ____