



CRITICAL CARE, PULMONARY & SLEEP

A S S O C I A T E S A PROFESSIONAL LLP

Notice of Privacy Practices

By signing this form, you are granting consent to Critical Care, Pulmonary and Sleep Associates, Prof. LLP to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, we will notify you. You may obtain a copy of the notice by contacting us at 303-951-0600. You have a right to request that we restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You are responsible for any and all changes, which your insurance carrier may not pay. You agree to pay all co-pay amounts due at the time services are rendered.

You authorize payment of medical benefits to be paid directly to Critical Care, Pulmonary and Sleep Associates, Prof. LLP as indicated by the signature on file/accept assignment on the claim form.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

No Show Policy: Please call if you are unable to make and appointment. CCPSA will charge patients \$50.00 if they repeatedly fail to show for appointments. Exemptions include emergencies and hospitalizations.

I understand that Critical Care, Pulmonary and Sleep Associates honors and adheres to the laws and principles of The Health Insurance Portability and Accountability Act (HIPAA) and the Privacy Rule therein.

Signature is certification that you have read and understand the above and that the information you have provided is true and correct.

Patient/Proxy Signature

Print Name

Date