HIPAA AND PRIVACY POLICY

My signature acknowledges that I have provided complete, accurate, information and authorizes the physician to examine and treat me.

□ I have received this physician's Notice of Privacy Practices.

□ Federal privacy rules permit my personal and medical information to be used and disclosed without my permission for billing, medical treatment and health care operations. For other purposes, my information will be released with my written permission.

□ I authorize release of any medical information necessary to process insurance claims, and I authorize payment of medical benefits directly to the physician.

□ I understand that all lab work is sent to an outside laboratory and I may be billed separately by the lab.

□ I understand that my insurance company may not cover services due to:

- Lack of Coverage
- Non-Covered Services
- Services not meeting their definition of "medical necessity"
- Too many services within your insurance carrier's definition of "time period"

□ I DO request a chaperon in the exam room during the physical portion of my examination.

□ I DO NOT request a chaperon in the exam room during the physical portion of my examination.

I have no objection to the doctor and/or his/her staff discussing my medical treatment with:

Dr. LOJEWSKI

Name_____ Relationship_____

Name_____ Relationship_____

I DO NOT OBJECT TO:
Phone calls left to my __home __place of employment __cell phone
__Messages left on my answering machine/voice mail
__Messages left with one of the people listed above.
Please Note: All mail will be sent to your home address and no information will be faxed or emailed to you *without your written permission*.

Printed Name _____

Signature _____ Date _____

This practice reserves the right to change its privacy practices as described in the Notice. Revised Notices will be made available upon request.