CHINGCHAI WANIDWORANUN, MD, PLLC
4001 9th Street North, Suite 228, Arlington, Virginia 22203 & 3901 Randolph Road Silver Spring, Maryland 20902
PHONE: (703) 387-0999 (301) 949-4994 FAX: (703) 387-0911 www.DrWanid.com

PRACTICE POLICIES, FINANCIAL RESPONSIBILITY & BILLING AUTHORIZATION

Relationship and Scope of Practice. By signing this agreement I am seeking medical service from, and entering into an agreement as detailed herein with Chingchai Wanidworanun, MD, PLLC which is a business entity whose addresses are shown above, and whose membership includes and is not limited to Chingchai Wanidworanun, MD hereinafter referred as **The Doctor**, who is also known as Dr. Chingchai Wanid. I accept that **Chingchai Wanidworanun, MD, PLLC** hereinafter referred to as **The Practice** provides medical services within the scope of general internal medicine and that there are other services including but not limited to travel medicine and vaccination that are not provided by **The Practice**. Each of my office visit with The Doctor defines my relationship with **The Doctor** and **The Practice** and the other parties involved, and its nature and its term. For example, **The Doctor** is my primary care doctor if I maintain an annual routine visit for health maintenance with **The Doctor**. If I see **The Doctor** occasionally for an acute illness such as cold or skin infection, then I have a short term relationship with **The Doctor** and **The Practice** similar to that of an urgent care visit. And if I involve **The Doctor** and **The Practice** in a long term relationship for a chronic illness, such relationship ends 1 year after my last office visit with **The Doctor**. The other parties that The Practice may involve with my consent may include but not limited to the insurance, testing facilities, referral physicians or the pharmacy, of which the nature and term of relationship are limited to and specific to each of the referral or each prescription. If I see another doctor without **The Doctor** and **The Practice** involvement, then **The Doctor** and **The Practice** is not in such relationship. I acknowledge that in some situations the government has the right and authority to get involved in my relationship with **The Practice** without the consent of mine nor **The Practice**. And if I want to involve my family member(s) or friend (s) in the relationsip, I must specify in writing on page 2 of this paper. Outside of the above mentioned relationship and its parties, **The Practice** has no part of and is no party to it.

Responsibilities. I will take responsibility that The Practice gets paid for all billable services, the list of which is displayed separately, related to my care rendered by **The Practice**. When the insurance is the payer for the service, The Practice has the right to accept or reject the insurance as payer for a specific covered service. And when **The Practice** agrees to accept my payment through my insurance(s), I will make sure that **The Practice** has adequate information to send bills to the insurance(s) by presenting a printed documentation, which can be verified by **The Practice**. When there is a contract between my insurance (s) and The Practice, my payment obligation to The Practice is only my portion as determined by the insurance, such as copay, coinsurance, non-covered services, as stipulated in the contract which will be shown in the paper usually called explanation of benefits which the insurance will send to me after the bill has been settled. I am aware that The Practice is not employed by my insurance (s) nor myself, so I will not expect The Practice to provide automatically a particular service when I show up or make a contact. The service is provided when The Practice agrees to and at a usual and customary office visit. And, I am aware that the insurance may not pay for a service when it is not part of an office visit. Also, I am aware that The Practice has no obligation to provide every single covered services as listed by my insurance in the book or somewhere. And If I must have a particular covered service that The Practice choose not to/cannot provide through my insurance, I will accept alternatives such as going to another provider, referral, using prescriptions and go to a pharmacy, etc. And in circumstances wherein I agree to accept services from **The Practice** and to pay using my own money I deem that there is no relationship between **The Practice** and my insurances pertaining to these particular transactions. I also accept full financial responsibility for all laboratory tests ordered by and pertaining to my medical cares that I seek through **The Practice**, which, I accept also, can in no way guarantee that my insurances will cover and pay for the tests. I also accept the responsibility to remind myself to communicate with **The Practice** for appointments and test results in a timely fashion as appropriate to the medical issues that I have. I understand that The Practice does not accept payments in personal checks as the banks have been charging excessively for returned checks.

Medicare Athorization of Benefits (if you receive medicare benefits). *If* applicable, I request that payment of authorized Medicare or MediGap benefits be made on my behalf to The Practice for any services furnished to me by The Practice. I authorize any holder of medical information about me to release to Health Care Financing Administration and its Agents any information needed to determine these benefits or the benefits payable for related services.

NAME OF PATIENT *INITIAL* *DATE*

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NOTICE OF PRIVACY PRACTICES

The HIPAA Privacy Rule enacted by the US Congress states patients' right to, and reinforces the protection of their medical records, or **Protected Health Information (PHI)**. This means that you, the patient, have right to the access and the privacy of your PHI. This also means that your physician must obtain your consent/authorization ***to use*** your PHI by the physician himself and his office employees/business associates, and ***to share*** the appropriate PHI with your pharmacies, referral physicians, health-related facilities, laboratories, and your health insurance, **in order to** conduct the usual medical care and obtain service reimbursement. The entire Privacy Rule is available at the reception desk and at our website: www.DrWanid.com.

HIPAA ACKNOWLEDGEMENT & AUTHORIZATION

Request for Services and Release of Records to Patients. I acknowledge and agree that I have personally requested medical care from *Chingchai Wanidworanun, MD and/or any other physician or health care practitioner in the employment of and at the office of* ***The Practice*** *located at 4001 9th Street, North, Arlington, VA 22203 or 3901 Randolph Road, Silver Spring, MD 20902*. I understand that I can obtain a copy of my medical record in the future at a usual and customary fee for making such a copy.

Authorization for Use or Disclosure of PHI. I authorize *employees and business associates of* ***The Practice*** to use and release my PHI for the purpose of usual and customary medical cares for myself and billing my health insurance. I understand that I have the right to revoke this authorization by sending my written request to Chingchai Wanidworanun, MD, at 4001 9th Street, North Suite 228, Arlington, VA 22203. I understand that my authorization is voluntary and that I may refuse to sign this authorization. **But by not giving such authorization**, *I also understand that* **The Practice** ***may be limited in its ability to provide services to me*** since the exchange of PHI is necessary in such activities as, but not limited to ordering tests, prescriptions, referrals, and billings to insurance. ***If*** *I choose not to sign the authorization, Then* ***The Practice*** *cannot get paid by my insurance, and I will pay* ***The Practice*** *for any services rendered at the time of service, and incurred to other parties at other medical facilities.*

Special Use Authorization for Use or Disclosure of PHI (Protected Health Information)

___ I do not authorize Chingchai Wanidworanun, MD, PLLC to release my PHI to anyone else.

___ I authorize Chingchai Wanidworanun, MD, PLLC to release my PHI to:
Name _____ Relationship _____
(Check "I authorize" and fill in above if you would like for us to share information from your medical record with someone you designate -- such as your parents, spouse, children, life partner, cohabitant or friend)

_____

Signature of Patient / Parent / Representative **Name** Relationship to Patient **Date**
Patient younger than 18 years must have parent read and sign.

Name of Patient:_____