



HIPAA RESTRICTION
DO NOT BILL INSURANCE
DO NOT DISCLOSE PHI TO HEALTH PLAN(S)

Name: (Last Name) (First Name) (Middle Initial)
DOB: MR#:
Acct#:

DOS:

I, the undersigned, do hereby request the Affiliated Covered Entity to restrict the release of health information concerning:

Patient: First Name Middle Initial Last Name DOB

To the following Health Plans:

Health Plan: Name Address Phone number

Health Plan: Name Address Phone number

I understand that the Affiliated Covered Entity requires payment in full of all estimated costs prior to or at the time of treatment. I further understand that this is an estimated cost and that I will be responsible for payment of any remaining balance after the final bill.

I understand the decision to restrict claim processing and disclosure of my personal health information to the above insurance company may not be rescinded after the service has been rendered.

I understand that I am responsible for notifying any physicians who provide care (such as my Primary Care Provider, Anesthesiologist, Pathologist, Radiologist, Emergency Medicine Physician, Hospitalist, etc) or other service providers of my desire to restrict disclosure of health information to the above health plan(s). I understand in the event that failure to pay any balance to the Affiliated Covered Entity will void this agreement.

Signature of Patient or Authorized Representative Date

Relationship to Patient

NHRMC EHR Facilities (See APM 14.5) Patient Registration: 1. Staff Name: 2. Scan form to Do Not Bill/Disclose PHI HIPAA 3. Fax scanned document to HIM 910.815.5675 4. Confirm receipt at 910.343.7109 HIM: 1. Place restriction flag on account in ROI module 2. Enter account comment: DOS ___/___/___ has been restricted. Do Not Bill or Disclose PHI for this DOS to the insurance company. Locate form AO-067 for more details. 3. Completed by: 4. Scan document to Do Not Bill/Disclose PHI HIPAA Non EHR Facilities Patient Registration: 1. Staff Name: 2. Enter account comment: DOS ___/___/___ has been restricted. Do Not Bill or Disclose PHI for this DOS to the insurance company. Locate form AO-067 for more details. 3. Keep original with admission papers. 4. Deliver copy of this document to a Medical Records employee. Medical Records (HIM): 1. Name: 2. Place Do Not Bill/Disclose PHI to Health Plan(s) sticker on patient's medical record jacket. 3. Keep copy with medical record.

THIS FORM IS PART OF THE PERMANENT MEDICAL RECORD





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Name: _____
(Last Name) (First Name) (Middle Initial)
DOB: _____ MR#: _____
Acct#: _____

IMPORTANT: READ THIS BEFORE SIGNING

Our records indicate that you have health insurance. You have requested, however, that part or all of your services today be paid by you, and not be billed to your insurance. Before you elect this self-pay restriction, you must read and agree to the following:

- You are required to pay the fees in full at the time we deliver the services based on our estimate of what they will cost. Please note that this amount is an estimate, and you are responsible for paying any remaining balances or additional fees. Payment in full of the final bill is expected within 60 days of invoice.
- You are responsible for any outstanding amounts on your self-pay account. If you do not pay the outstanding amounts within 60 days, the law allows us to bill your insurance for the services regardless of the self-pay restriction. In addition, if your form of payment is by check or credit/debit card, and your financial institution declines the payment, we will bill your health plan after our attempts to collect payment.
- This self-pay restriction only applies to information shared with your health plan. It does not restrict our ability to share your information for your treatment, our health care operations, or for the other purposes set forth in our Notice of Privacy Practices. It also does not prevent any disclosures that we are required to make by law.
- You must notify us of the self-pay restriction at the beginning of your visit. If your visit is already underway, billing may be in process and we may not be able to honor the restriction.
- You must agree that you will not attempt to file a claim with your insurance carrier for the restricted services, unless you have already paid us in full and the account is satisfied.
- If you wish to pay for certain services, but bill others to insurance, please note that we may not be able to separate them out. For example, many services are paid for as a lump sum and cannot be separated; other services may require that we show the health plan the self-pay service in order to be paid for the covered services. We also may not be able to separate out the services due to other billing restrictions or processes that prevent us from keeping the information from the health plan. As such, you may be required to pay for the entire bundle of services, even though you only want to restrict part of them. As a possible alternative, you may choose to make a second appointment and reserve the restricted service for that appointment, which can be self-pay. Please note that you may incur duplicate costs or undergo duplicate procedures at the second appointment.

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DOB: _____ MR#: _____

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- This restriction applies only to today’s visit/service/item. If you want the same information restricted from your health plan at future visits, you must make a new request and pay in full for those services as well; otherwise, your next visit will be billed to your insurance.
- This restriction only applies to today’s visit at this particular location. If you elect the self-pay restriction at one of our practices, but then go to one of our hospitals or another one of our practices, you must notify those locations that you want the restriction for those visits as well. Your restriction will not carry over.
- It is your responsibility to notify any other providers involved in your care that you do not want the services they provide to be billed to your insurance. This includes notifying any providers who are involved in today’s visit/service/item, such as consulting physicians, emergency medicine physicians, primary care physician, radiologists, pathologists, pharmacists, etc. For example, if we write a prescription for you today and you go to the pharmacy to fill it, you must alert the pharmacy that you want to pay for the prescription yourself, instead of having it billed to insurance. Likewise, we do not employ or control some of the providers involved in your care, such as radiologists or pathologists; you must notify them as well if you do not want them to bill your insurance for the services you are being provided. You must also notify any laboratories that are billing for the restricted services if they are not part of the location you are visiting today.
- If you change your mind after you elect the self-pay restriction and later wish to have the services billed to your health plan, there may be situations where we cannot do so. For example, if the services you receive require pre-authorization from or notification to the health plan, but we were not able to secure the necessary authorization because of your self-pay restriction and the health plan refuses to pay, then you are still responsible for the full amount.

By signing below, you are confirming that you have read the above information, and that you understand, agree to, and accept the risks and consequences of the self-pay restriction. You also agree to release NHRMC Physician Group, including its subsidiaries and affiliates, from any claims or liability associated with or arising from your decision to elect the self-pay restriction. You understand that this restriction only applies to the services provided today at this visit and at this location, and that you are responsible for any notifications to other providers. You agree to pay the estimated cost of today’s visit in full and that you are responsible for any remaining amounts due. You agree that we may bill your insurance for any self-pay services that are not paid in full within 60 days of invoice.

Signature of Patient or Authorized Representative

Date

Name of Patient or Authorized Representative

Relationship to Patient

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