Park City:
2200 Park Ave. Bldg D. Suite 100
Park City, Ut 84060

Old Mill Medical Center:
6360 So. 3000 East, Suite 210
Salt Lake City, UT 84121

HEIDEN ORTHOPEDICS

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# ACKNOWLEDGEMENT OF PRIVACY PRACTICES

**Name of patient: _____**

**The purpose of this Authorization and Release form is for your protection. The H.I.P.A.A. (Health Insurance Portability Accountability Act) of 1996 was created with the sole purpose and goal of protecting patient's medical records and financial information. We will not share this information without your consent. We urge you to complete this form to allow us to better serve and protect your private information. We appreciate your attention to this sensitive matter. Please be specific when designating your choices.**

I (patient/parent/guardian) authorize the staff of Heiden Orthopedics to release any:

☐ FINANCIAL INFORMATION ☐ MEDICAL INFORMATION

to the following people:

1. _____ 2. _____

3. _____ 4. _____

**Heiden Orthopedics will not release my medical information to individuals without a signed release form.**

**Signature _____Date _____**

# FINANCIAL CONSENT

**By signing below I agree to the following:**

- **I will provide correct insurance information. Heiden Orthopedics will bill my insurance company, my insurance company will directly pay Heiden Orthopedics.**
- **To pay the allowable balance of medical bills after my insurance company has paid.**
- **To pay interest on all past-due amounts (>60 days)( at the rate of 18% per annum or 1.5% per month until paid in full).**
- **To pay any cost incurred to collect my payment, such as certified mail.**
- **To allow Heiden Orthopedics to refer my unpaid account balance to a collection agency and to pay the collection fee up to 33% of the principal amount in addition to the principal amount. (Utah Code Annotated, sec. 12-1-11)**
- **The terms of this paragraph shall apply to all amounts incurred by me or by any individual for whom I have legal responsibility.**

**Signature _____Date _____**