Beverly Hills Digestive Care

Shahab Mehdizadeh, M.D., M.A.

Notice of Privacy Practices

To Our Patients: This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information.

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by law enforcement official.
4. When necessary to reduce or prevent serious threat to your health and safety or the health and safety of another individual or the public. We shall only make disclosures to a person or organization able to help prevent a threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. Communications. Your can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than at work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request, however, if we do agree, we are bound by our agreement except when otherwise required by law, emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the Office Manager.

4. You may ask us to amend your health information if you believe it is incorrect or incomplete and as long as the information is kept for or by our practice. To request an amendment, your request must be in writing and submitted to the Office Manager. You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice, or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the Office Manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. If you have any questions regarding this notice or our health information privacy policies, please contact the Office Manager.
8. Dr. Mehdizadeh is licensed by the Medical Board of California, 800-633-2322.
9. Dr. Mehdizadeh is not contracted with your insurance and you have the right to select an in-network doctor.
10. We provide you with cost estimates to keep you informed of your maximum healthcare cost. Estimates are your total out-of-pocket cost for the physician portion of your care and may be additional to any in-network cost sharing and may not count towards your deductible or out-of pocket maximum.

Notice of fees and charges:
No-show fee for office appointment: $50.00
No-show fee for procedure: $ 250
Chart copy: $30
Late fee for bills over 30 days past due: $30
Prior authorization: $25

Notice of Billing Procedures:
Please be informed that Dr. Shahab Mehdizadeh may not be a contracted provider with your insurance company and it is your responsibility to understand your benefits prior to your visit. You may be responsible for the remainder of balance after your insurance has made payments. Payments are due within 14 days from the date of the bill. Delinquent accounts may be submitted to collections. Please not that a 35% Collections and/or Attorney Fee will be added to the principal balance and will be forwarded to a third party collection agency for processing.

I hereby acknowledge that I have been presented with a copy of Shahab Mehdizadeh, M.D., Notice of Privacy Practices and billing procedures.

Signature_____

Print Name_____ Date _____

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Patient Record of Disclosures

In general, the HIPAA privacy rule gives the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply)

HOME TELEPHONE_____
_____Ok to leave message with detailed information
_____Leave message with call back number only

WORK TELEPHONE_____
_____Ok to leave message with detailed information
_____Leave message with call back number only

CELLULAR TELEPHONE_____
_____Ok to leave message with detailed information
_____Leave message with call back number only

WRITTEN COMMUNICATION
_____Ok to mail to my home address
_____Ok to mail to my work/office address
_____Ok to fax to this number_____

OTHER INSTRUCTIONS_____
_____
_____

Patient Signature_____ Date_____

Print Name_____