Request for Restriction on Use or Disclosure of PHI
INSURANCE WAIVER

Please complete this form to request that our practice restrict the use or disclosure of your health information for purposes of payment that would otherwise be allowed under HIPAA regulations, provided the services have been paid in full by the patient.

SECTION 1:
Neuse Valley Internal Medicine must accept any request for restriction to release health information to a Health Insurance Plan. It is required that a notice be provided to all patients who make this request.

- ❑ I have elected to pay for my medical services and request that it not be billed to my health insurance Plan for date of service _____/_____/_____

  Patient Name (Please print)_____

  Patient Account # _____

  Patient DOB _____

SECTION 2:
Please indicate whether you would like all services for the visit to be restricted or if you like to restrict select services.

- ❑ Restrict **ALL** services including Office Visit, Labs, Radiology, and other Ancillary services.

- ❑ Restrict **SELECT** services. Please indicate which services you would like to restrict below.

Service(s): _____

_____

SECTION 3:
Any restrictions on release of health information to your Health Insurance Plan will be honored. All restricted services are not subject to a discount and are expected to be paid at the time of service. Please note that once you have submitted this written restriction, we will not be able to file the restricted services to your Health Insurance Plan should you change your decision.

Please sign below to indicate that you have received & acknowledge this notice.

I acknowledge that I am signing this statement voluntarily and I will be fully responsible for the total billed charge(s) for any restricted services received. I acknowledge that I am waiving my right to have restricted services billed to my Health Insurance Plan.

Today's Date (mm/dd/yyyy) _____

Name (please print) _____

Signature _____