

Liberty Medical Center  
1504 NE 96TH STREET  
Liberty, MO  
816-415-2233

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

*Obtain payment from third-party payers.*

*Conduct normal healthcare operation, such as quality assessments and physician certifications.*

*Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.*

I have been informed by you of your "Notice of Privacy Practices" containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such "Notice of Privacy Practices" prior to signing this consent. I understand that this organization has the right to change its "Notice of Privacy Practices" from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the "Notice of Privacy Practices".

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my request restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this account.

**I understand that there is a \$25 no-show fee I will be charged if I fail to arrive for an appointment without giving at least 24 hours notice prior to not showing up. There will be a \$40 charge per month on any balance that is not paid within 30 days of the due date.**

We have adopted a policy that requires authorization from the patient to leave a detailed message for that patient. This is to protect the privacy of the patient and to protect the physician and staff of this practice from violating the patient's confidentiality. If there is not a signed consent on file, Dr. Malisos or the staff will only leave their name and telephone number on an answering machine, voicemail, or with a person answering the phone asking the patient to return the call.

By completing the consent below, you are allowing this medical office and its staff to leave a message on an answering machine, email, voicemail, or with a specified individual. You can specify what information is left and with whom. By signing, you are also consenting to the mailing, emailing or faxing of any results requested by you or another physician involved in your care.

I give my consent to Rodney Malisos, MD and the entire staff of Liberty Medical Center to leave a message regarding scheduling, treatment, surgery, lab, radiology results, or other information as necessary

\_\_\_\_\_ on answering machine, email or voicemail at home or cell phone.

\_\_\_\_\_ on answering machine, email or voicemail at work.

\_\_\_\_\_ With \_\_\_\_\_ Relationship \_\_\_\_\_

With \_\_\_\_\_ Relationship \_\_\_\_\_

\_\_\_\_\_ **I DO NOT** consent to medical messages being left at home, work, or with any other person.

I wish to make an individual appointment each and every time I need to be notified by anyone from this office staff for any reason.

\_\_\_\_\_  
Patient's Name (Please Print)

\_\_\_\_\_  
DOB

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date