ACKNOWLEDGMENT

Patient Rights and Privacy Practices

I have received the Notice of Privacy Practices and the Patient Rights and have been provided an opportunity to review it.

Name: ______________________________ Date of Birth ______________

Signature: ______________________________ Today's Date: ______________

I understand if I refuse to sign this that the office reserves the right to refuse medical treatment.

Authorization of assignment of benefits and release information:

I authorize payment of medical benefits to the provider of services rendered in the future, without obtaining my signature on insurance claims submitted; and the signature will bind me as though I personally signed the claim. I understand I am obligated to forward any and all checks issued by my insurance company to the professional(s) that provided the service. I understand I am responsible for all charges regardless of insurance coverage. **NOTE:** Several surgeries require an assistant and fee is not always covered by insurance. If any account should be referred to a collection agency I will be responsible for any and all collection and or legal fees. Initial__________

I understand that it is **my responsibility to contact my insurance company with any issue regarding medical benefits**. While this office may contact your insurance company as a courtesy to you, we are not authorized to guarantee your insurance company will fully cover your procedure or office visit. Any portion not covered by your insurance company will be the patient's responsibility. Any portion of my deductible collected prior to surgery, is an *estimate*, and may or may not cover all amounts due. **I understand that I must provide *all current insurance information*** to the office staff, prior to my appointment and/or surgery, or claims may be denied by the insurance company/companies, leaving patient responsible.

Initial__________

I authorize the full and unconditional release from all entities, of any and all, medical information necessary for continuity of care.
I also hereby authorize the release of medical information to the following individuals:

Name______________________ Phone #______________ Relationship to Patient__________________

Name______________________ Phone #______________ Relationship to Patient__________________

I affirm that I have read, understand and accept the office policy.

Signature: ______________________________ Today's Date: ____________

Social Security #: ______________________ Phone #______________________

Home Address: ____

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Email Address: ____

Emergency Contact: ______________________ Phone #__________________

Primary Care Doctor ______________________ Phone #__________________