ACKNOWLEDGEMENT

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 will fully cover your procedure or office visit. Any portion not covered by 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 individual:

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: _____

Email Address: _____

Emergency Contact: _____ Phone #:_____ Relationship:_____

Pharmacy: _____ Cross Streets: _____

Primary Care Doctor: _____ Practice Name: _____

Primary Care Phone # _____

I consent to receiving appointment reminders and other healthcare communications/information through text at this number _____ Initial _____