H.H.S. Pursuant to the Health Insurance Portability and Accountability Act of 1996, I acknowledge that I have received a copy of ***NOTICE OF PRIVACY PRACTICES:***

INITIAL ____________________ **DATE** ____________________

CONSENT TO TREAT: I request and give consent to my physician to provide and perform such medical/surgical care, tests, procedures, drugs and other services and supplies as are considered necessary or beneficial by my physician for my health and well being. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

INITIAL ____________________

RELEASE OF MEDICAL INFO AND AUTHORIZATION TO PAY INS BENEFITS: I authorize my physician to release information from my medical record to my insurance carrier(s), or government agency for the processing of claims for medical benefits. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to my physician, on my behalf.

INITIAL ____________________

MEDICARE CERTIFICATION: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize my physician who treats me, to release information from my medical record to the Social Security Administration and/or the Medicare program or its intermediaries or carriers. I request that payment of authorization benefits be made directly to my physician treating me, on my behalf.

INITIAL ____________________

FINANCIAL AGREEMENT: I understand all accounts are the full responsibility of the patient and/or the patient's responsible party/guarantor. My physician will assist patients in obtaining insurance benefits when those benefits are assigned to my physician. It is the patient's responsibility to make sure insurance payments are processed and paid promptly to my physician. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

INITIAL ____________________

PATIENT'S SIGNATURE ________________________ **DATE** ____________

Parent/Guardian ________________________ **DATE** ____________

ADVANCED DIRECTIVE

1. **Do You Have A Living Will? Yes** ______ **No** ______
   A copy may be needed for your chart.
   A Copy Was Received By This Office. **Date** ____________

2. **Have You Appointed A Health Care Representative? Yes** ______ **No** ______ **Read and Sign Below**
   I give my consent and authorization for this person or persons I list below to act as my Health Care Representative to receive any and all information from my medical records, or discuss any and all aspects of my medical care.
   I also give consent, and authorization for the person, or persons to be notified any time I have an appointment.
   I also understand that I may revoke this privilege at any time by submitting my request in writing to this office.
   Name of your Health Care Representative ____________________ **Date** ____________
   Name of your Health Care Representative ____________________ **Date** ____________
   Signed By: ____________________ **Date** ____________
   Witnessed By: ____________________ **Date** ____________

3. **Have You Given Anyone Your Power Of Attorney? Yes** ______ **No** ______ **Please list below**
   A copy may be needed for your chart.
   A Copy Was Received By This Office. **Date** ____________
   Name ____________________ **Relationship** ____________ **Date** ____________

Release of Protected Health Care Information Via Telephone To Answering Machine, Or Voice Mail
I give my consent and authorization for the Medical, or Billing Staff of my Physician's Office to leave protected Health Care Information about me or for me on my answering machine or voice mail via the telephone at the number I have listed below. I understand I may revoke this privilege at any time by submitting my request in writing to this office.

Number ____________________ **Initial** ____________