CONSENT FOR USE & DISCLOSURE OF HEALTH INFORMATION

BENEFITS TO PHYSICIAN: I hereby authorize payment by my insurance be made directly to my physician for services and procedures rendered at the time of the visit.

RELEASE OF INFORMATION: I hereby authorize release of information to my insurance for claim purposes. A Photostat copy is as valid as the original.

By signing at the bottom of this page, you consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and health operations. You have a right to read our Notice of Privacy Practice before you decide to sign this consent. We encourage you read it carefully and completely. We reserve the right to change our privacy practices as described in our Notice. If we change our privacy practice, we will issue a revised copy, which contains the changes. Those changes may apply to any of your protected health information that we maintain.

OFFICE POLICIES

Thank you for taking time to review our policies. After you have read our policies carefully, please sign and date at the bottom of the page. Please feel free to ask or share any questions or specific concerns you may have regarding these policies.

- **MEDICARE PATIENTS—It is your responsibility to notify Medicare of any supplemental insurance you may have. If they are not notified so that Medicare can forward your claim, you could be responsible for the balance.**
- **Co-payments—By law, we must collect your carrier designated co-pay at the time of service. Please be prepared to pay at each visit.**
- **Referrals—If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it prior to and have it with you at the time of your visit, unless it has been forwarded to our office prior to your visit. Please check with the front desk prior to your visit if you are uncertain. If you do not have a valid referral with you or on file, you will be required to RESCHEDULE YOUR APPOINTMENT.**
- **Self-pay—Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.**
- **Account Balances—You are responsible for timely payment of your account.**
- **Insurance—It is the patients responsibility to determine whether we are in-network or out-of-network for your particular insurance policy or group.**

I understand all of the above and hereby state that the information given by myself or my representative is correct to the best of my knowledge.

My signature indicates that I have read all of the above and grant the request for all authorizations listed above.

Signed by Insured_____ **Date**_____

WE ACCEPT CASH, CHECKS, MASTERCARD, VISA AND DISCOVER