PRIVACY PRACTICES

I _____ acknowledge that I have seen a copy of the notice of Privacy Practices. I authorize the release of any medical or other information necessary to process my insurance benefits. I authorize payment of medical payments to the undersigned physician or supplier, for services provided. I agree to be financially responsible for all the charges incurred. I hereby consent to the release and disclosure of my medical records to enable or facilitate the collection, verification, or settlement of my account for any charges due. I agree to pay for services rendered to me or the above named patient, at the time of service. If it becomes necessary to take further action to collect payments on my account, I agree to pay collection agency fees.

SIGNATURE OF PATIENT/PARENT OR GUARDIAN **DATE**

Do you have a NEXT OF KIN or P.O.A. that is allowed to have access to your medical information? CIRCLE ONE:

YES Full name & phone number:

NO

SIGNATURE OF PATIENT **DATE**