



Assignment of Benefits and HIPAA Notice

Assignment of Benefits: I acknowledge financial responsibility for all facility and physician/provider(s) fees. I understand that the physician billing office will file my insurance claim and I assign direct payment to the physician all payments made under the terms and provisions of my policy. I further understand that any disputes on coverage are between my insurance carrier and myself and I will be responsible for payment for denied services regardless of the outcome of my dispute. I acknowledge financial responsibility for all charges if inaccurate insurance information is given at time of service and the information is not corrected prior to my insurance company's timely filing limit.

Initial

Acknowledgement of receipt of Notice of Privacy Practice regarding protected health information

I have received the Practice's Notice of Privacy. Photocopies of this document are to be as valid as the original.

Initial

Communication Preferences Regarding PHI

To assist in your care, it may be necessary to release our *Protected Health Information* to someone other than yourself. To whom may we speak to?

- | | | |
|--------------------------|--------------------------|----------------------|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Spouse_____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Parent_____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Step-Parent_____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Caregiver_____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Other Person(s)_____ |

How should we communicate with you regarding your medical care:

- | | | |
|--------------------------|--------------------------|---|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Your answering machine/voice mail at home |
| <input type="checkbox"/> | <input type="checkbox"/> | Your voice mail at work |
| <input type="checkbox"/> | <input type="checkbox"/> | Your email |

Patient or Representative Signature

Date

Print Name

Account # (Office use only)