YOUR PRIVACY

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of Doctors Medi Center's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the notices, and I request the following restriction(s) concerning the use of my personal information:

_____

_____

Further, I permit a copy of this authorization to be used in place of the original,and request payment of medical insurance benefits either to my self or to the party who accepts assignment.
Regulations pertaining to medical assignment of benefits apply.

HIPPAA RELEASE

We only release protected health information to people you authorize. Please note if there is anyone you would like to pre-authorize to receive information on you, your financial arrangements or you course of treatment.

Listed below are the people I would like to receive information

Name	Name
Phone #	Phone #
Relationship to Patient	Relationship to Patient
Information to Release: ☐ Appointments at DMC ☐ Appointments (referrals) at outside facilities ☐ Insurance and billing information ☐ Diagnostic testing results (labs, x-rays, EKGs, etc)	**Information to Release:** ☐ Appointments at DMC ☐ Appointments (referrals) at outside facilities ☐ Insurance and billing information ☐ Diagnostic testing results (labs, x-rays, EKGs, etc)
☐ **This is also my emergency contact**	☐ **This is also my emergency contact**

Patient Signature _____ **Date** _____

Signature of guardian (if under 18) _____ **Date** _____

FINANCIAL POLICY

Payment is expected at the time of service.

For patients without medical insurance, we offer discounted self-pay prices.

For patient with medical insurance, we cannot guarantee that your insurance carrier will pay for your visit, or that visit will apply to your in-network benefits. We will, however, make every effort to ensure that your claim is paid at the best rate for you. After verification of benefits, if your annual deductible has been met, we will glad to accept the co-insurance portion for services rendered. For your convenience, our staff will be glad to file your primary and secondary insurance claims: however, ***final responsibility is ultimately the patient's.***

PATIENTS **WITH** MEDICAL INSURANCE

I authorize my insurance benefits be paid directly to directly to Doctor's Medi Center and understand that I am financially responsible for any balance left. I understand that getting a monthly bill is a privilege and I pledge to pay my bill in full within three (3) monthd of my office visit.

Guarantor Signature_____ **Date**_____

PATIENTS **WITHOUT** MEDICAL INSURANCE

I understand that I am getting a discount today and agree to pay my bill in full prior to leaving.

Patient Signature_____ **Date**_____