Clinic:

HIPAA and Insurance Payment Consent

Contact

Date (MM/DD/YYYY)

PERSONAL INFORMATION

Name

Title First MI Last

Address

City State Zip

Date of Birth Gender Female Male Soc. Sec.#

MM/DD/YYYY

Home phone Mobile phone Work phone

ALTERNATE CONTACT INFORMATION

Name Is primary contact

Title First MI Last

Address

City State Zip Signing on behalf of patient

Relationship to patient

Home phone Mobile phone Work phone

PATIENT HIPAA CONSENT

I understand that I have certain rights to privacy regarding my protected health information according to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize the clinic to use and disclose my protected health information for the purpose of:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from insurance or third party benefit plans;
- The day-to-day healthcare operations of the clinic such as quality assessments and provider certifications.

INSURANCE AND PAYMENT

I authorize the clinic to provide medical treatment and file my insurance and third party benefit claims. I authorize payments of medical benefits to be paid directly to the clinic. I accept full responsibility of all services and charges not paid for by my insurance company or third party benefit plan.

I accept full responsibility for all charges in the event that I have no insurance or third party benefits. Charges 30 days past due are subject to late fees.

PATIENT SIGNATURE

Patient signature or legal custodian

Please sign here