My signature acknowledges that I have provided complete, accurate, information and authorizes the Physician to examine and treat me.

____I have received this physicians Notice of Privacy Practices

____Federal privacy rules permit my personal and medical information to be used and disclose without my permission for billing, medical treatment and health care operations. For other purposes, my information will only be released with my written permission.

____I authorize release of any medical information necessary to process insurance claims and I authorize payment of medical benefits directly to the Physician.

____I understand that all lab work is sent to an outside laboratory and I may be billed separately by the lab and I am able to receive copies of those reports from this office.

____I understand that my insurance company may not cover services due to:

Lack of Coverage
Non-Covered Services
Services not meeting their definition of "medical necessity"
Too many services within your insurance carrier's definition of "time period"

☐ I DO ☐ I DO NOT request a chaperone in the exam room during the physical portion of my examination. I have no objection to the doctor and/or his staff discussing my medical treatment.

Dr. _______________________________(Primary Care Physician)
Name _____________________________ Relationship: ______________________
Name_____________________________ _ Relationship: ______________________

I DO NOT OBJECT TO:

Phone calls to my ___ home ___place of employment ___cell phone
___Messages left on my answering machine/voicemail.
___Messages left with one of the people listed above.

Please Note: All mail will be sent to your home address and no information will be FAXED or EMAILED to you without your written permission.

Printed Name: ____
Signature: ____ Date: _______________

This practice reserves the right to change its privacy practices as described in the Notice. Revised Notices will be made available upon request.

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