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 None

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