DEXTERITY SURGICAL

Agreement and Understanding of Policies

Please complete this form on the computer and e-mail it to us at office@dexteritysurgical.com. You may also print it out and bring it to your first visit. If you do not already have an appointment, we will call you within 24 hours of the next business day to schedule your visit.

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Virginia Hung all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance company. I authorize the use of my signature on all insurance submissions. Dr. Virginia Hung may use my healthcare information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

HIPAA Notice of Privacy Practices

I have read the HIPAA notice of privacy practices and understand my rights contained in this notice.

By the way of my signature, I provide this practice with my authorization and consent to use and disclose my protected health information for the purpose of treatment, payment, and healthcare operations as described in the privacy notice.

_____ _____

Print name of patient, parent, guardian or personal representative | Relationship to patient

_____ _____

Signature of patient, parent, guardian or personal representative | Date

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