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PATIENT INFORMATION CONSENT FORM/FINANCIAL AGREEMENT/RELEASE FORM
PATIENT INFORMATION CONSENT FORM

I have read and understand the Norm of Patient Information Practice. I understand that my Personal health information may be used for the proposes of carrying one treatment, obtaining payment evaluating the quality of services provided and any administrative operations related to treatment or payment I understand that I have the right to restrict how my personal health information is used and disclosed *for* treatment, payment and administrative operations if I notify you. I also understand that such requests for restriction will be considered on a case by case basis, but such requests for restrictions may not necessarily be accepted.

I hereby consent to the use and disclosure of my personal health Information for purposes as noted in the Patient Information Practices. I understand that I retain the right to revoke this consent by notification in writing at any time.

FINANCIAL AGREMENT/MEDICAL RELEASE

We participate with most Insurance Companies. Check your provider directory or contact your insurance to verify that this is a participating provider before members are rendered. Patient is responsible for the deductible, co-pay and co-insurance. When the insurance has processed your claim, they will send you an EOB (explanation of benefits). The EOB explains payment and patient responsibility. Patient payment Is required within 30 days of insurance payment Co-pays are required at the time service.
Patient are responsible for obtaining prescriptions and referrals from their Primary physician.
Self Pay accounts must be paid at the time of the service unless other arrangements have been made.

INSURANCE AND MEDICAL RELEASE FORM

I hereby authorize any insurance benefits to he paid directly to the physician providing services and recognize my responsibility to pay for all non covered services. I also authorize the physician to release any information necessary to process an insurance claim

A PARENT OR GUARDIAN WHO WILL BE RESPONSIBLE FOR PAYMENT OF THE BILL AT THE TIME OF THE SERVICE MUST ACCOMPANY THE CHILD. WE CANNOT BE BOUND BY ANY DIVORCE OR OTHER FAMILY RELATIONSHIP CONTRACTS.

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Patient Name **Date**

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Signature