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 MM/DD/YYYY

Gender ◯ Female ◯ Male Soc. Sec.#

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 using mouse or finger on touch screen