

LAUREL MEDICAL ASSOCIATES
PATIENT ACKNOWLEDGEMENT/CONSENT FORM

Laurel Medical Associates "Notice of Privacy Practices" provides information about how we may use and disclose protected health information about you. Please acknowledge reading this office's "Notice of Privacy Practices" by initialing below.

Initials

Our "Notice of Privacy Practices" states that we reserve the right to change the terms described. Should this happen, you will receive a copy by mail.

Initials

You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree to your restrictions, but if we do, we are bound by our agreement with you.

Initials

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent in writing, except where we have already made disclosures in trust on your prior consent.

I request that payment of authorized Medicare/Insurance carrier benefits be made on my behalf to Laurel Medical Associates for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare/Medicaid Services and its agent and/or any other Insurance Carriers for which I have coverage, and information needed to determine these benefits or the benefits payable for related services. I agree to provide all referral and treatment plan(s) as required by my insurance carrier(s). All co-pays must be paid at the time of service in accordance with the contracted Insurance Carrier agreements.

Signature

Today's Date