ALLIANCE WOMEN'S HEALTHCARE

Jonathan Snead, M.D., F.A.C.O.G & Angela George, WHNP-BC
10932 Old Denton Rd, Suite 100
Keller, TX 76244
Phone: 817.741.9663 Fax: 817.741.3691

Date: _____

PERSONAL INFORMATION

Patient Name: _____ Date of Birth: _____

SSN: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated Gender: ☐ F Race _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

I authorize normal lab result messages to be left at the following phone number: _____

Pharmacy Name: _____ Pharmacy Location: _____

Email address: _____ Referred by: _____

EMERGENCY CONTACT

Name: _____ Phone: _____ Relationship: _____

BILLING INFORMATION:

Primary Insurance Company: _____ Ins Phone # _____

Claims Mailing Address _____

Policy Number: _____ Group Number: _____ Eff. Date: _____

Policy Holder: _____ Relationship to policy holder: _____

Policy holder's SSN: _____ Policyholder's date of birth: _____

Policyholder's Employer: _____

Secondary Insurance Company: _____ Ins Phone # _____

Claims Mailing Address: _____

Policy Number: _____ Group Number: _____ Eff. Date: _____

Policy Holder: _____ Relationship to policy holder: _____

Policy holder's SSN: _____ Policyholder's date of birth: _____

Policyholder's Employer: _____

May we leave a voice mail at your preferred method of contact?_____

Patient's Signature: _____ Date: _____

ALLIANCE WOMEN'S HEALTHCARE
DR. JONATHAN SNEAD, MD, FACOG
& ANGELA GEORGE, WHNP
OBSTETRICS / GYNECOLOGY / INFERTILITY

Important Information for our Patients Regarding Annual Well Woman Exams after new health care laws

The purpose of this handout is to clear up any confusion caused by the complicated coding and billing rules dictated by Federal Law and your Insurance Carrier. These regulations can be quite complicated and generate many questions from our patients.

Your Annual Wellness visit WILL INCLUDE:

- A complete history and examination in additional to a breast and pelvic exam.
- There also will be questions about other medical conditions and counseling on risk factors such as: sexually transmitted disease prevention, diet and exercise, stress management, smoking cessation, Self Breast Exams, birth control, menopausal symptoms and hormone replacement therapy.
- The collection/preparation of Pap Smear specimen to the laboratory is included. LabCorp or GenPap will bill separately for the processing/testing of the Pap Smear.
- Appropriate laboratory and diagnostic testing, such as a mammography and DEXA, may be ordered and will be billed separately by those entities.
- In addition to the above, discussion about any problems or conditions that are under control, are considered an integral part of the Well Women Exam and cannot be billed as a "Sick Visit" under Federal Compliance rules.

NOT included in your Annual Wellness visit:

- Administration of vaccines as well as other procedure are not included.
- IMPORTANT: If a separate new or uncontrolled problem (ANYTHING OTHER THAN "NORMAL") is identified during the course of the Annual Exam, we are required to submit an additional office visit claim separately from the Screening services based on the documentation in the medical record of the service provided.
- If the additional services are denied by your insurance plan, you agree to accept financial responsibility.

Please understand that our Providers cannot comply with any requests to improperly alter the medical records for the purpose of obtaining payment.

Payment in full will be required for all associated copayments and deductibles at the time of service.

Providing you with high quality healthcare remains our first priority. We thank you for choosing us to assist you with your healthcare needs.

Respectfully,
Jonathan C Snead, M.D., F.A.C.O.G. and Angela George, WHNP

Patient Signature_____ DOB _____Date _____

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10932 Old Denton Rd, Suite 100
Keller, TX 76244
Phone: 817.741.9663 Fax: 817.741.3691

AUTHORIZATION TO RECEIVE PAST MEDICATION HISTORY

I authorize Dr. Jonathan Snead and Angela George WHNP, to electronically obtain my current and past medication history.

Patient's Printed Name: _____ DOB: _____

Patient's Signature: _____ Date: _____

ALLIANCE WOMEN'S HEALTHCARE
DR. JONATHAN SNEAD, FACOG
& ANGELA GEORGE, WHNP
OBSTETRICS / GYNECOLOGY / INFERTILITY

Financial Agreement

Parties – Jonathan C. Snead, MD PA d/b/a Alliance Womens Healthcare (otherwise known as "we" "our" "us" or "Alliance Women's Healthcare") and _____ (otherwise known as "you" "your"). The "claim" is based on the services provided for any given date of service. There may be more than one "claim" as well as more than more than one "date of service" or "service" provided. This Agreement contemplates all claims for all services rendered on any given day.

The parties agree to the following:

- It is your responsibility to provide us with your most current insurance information. If you change insurance or fail to maintain insurance, you must notify our office immediately if you are a current patient. A "current patient" is any OB patient who has not delivered or any other patient who has an appointment of any kind.
- If you fail to provide accurate insurance to us information in a timely manner (prior to your insurance termination), your insurance company may deny your claim. If the claim is denied, you will be financially responsible for services rendered.
- Please note, as medical providers, our relationship is with you, not your insurance company. Your insurance is a contract between you, your insurance company and possibly your employer. It is your responsibility to know and understand your benefits and eligibility.
- If you have **Medicaid** coverage of any kind, you must notify us prior to your visit. This is part of your agreement with Medicaid. **Failure to notify us and provide written documentation at each appointment verifying** Medicaid coverage will result in full financial responsibility for services rendered.
- We may accept assignment of insurance after verification of your coverage. Please be aware that some or perhaps all of the services provided may not be covered in full by your insurance company. **Therefore, you are financially responsible for services not covered by your insurance company. It is your responsibility to know your benefits.**
- Prior to receiving services, you must verify that we are participating providers for your insurance company by calling your insurance company or logging into your carrier's website.
- We charge what is usual and customary for our area. You are responsible for payment if your insurance company disputes payment for your claim.
- Copayments, coinsurance and/or deductibles are due at the time of service. We will provide a good-faith estimate the amount you owe based on information we receive from your insurance company. This will only be an estimate and in no way does it imply a contractual arrangement indicating an agreed upon amount actually due. We will not know how much is actually due by you until we receive payment from your insurance company.
- You are responsible for paying the full amount determined by your insurance company once they have paid your claim – regardless of our estimation. Please review your explanation of benefits or contact your insurance company if you have any questions.
- **We must have a current copy of your insurance card on file. We require a copy of your driver's license/picture ID and insurance card at every visit.**
- You must provide your most current billing address, telephone numbers and any other important contact information. If your address or contact information changes, modifications can be made via our secure patient portal at www.alliancewomenshealthcare.com
- We will send a statement to the billing address on file to notify you of any balances you may owe. If you have any questions regarding your balance, it is your responsibility to contact our office after receipt of the initial statement. We will assume you do not dispute the charges if you do not contact our office within 30 days of receipt of a statement.
- **Payment in full is due upon receipt of the statement.** Patient balances not paid in full within 30 days of the statement issue date are deemed past due. **Past due accounts may be subject to a $5.00 monthly late fee and may be referred to a professional collection agency and/or attorney for further collection activity**. You will be responsible to pay all collection costs incurred, including but not limited to attorney's fees, court costs and interest if applicable. The laws of the state of Texas apply and venue is proper in Tarrant County.
- If you are not able to pay the balance due in full, you must contact our office to discuss a payment schedule. If you fail to make payments as agreed upon, your account may be referred to a professional collection agency and/or attorney.
- If your account is assigned to a professional collection agency, you will be notified by certified mail that you will no longer be able to receive services from Alliance Women's Healthcare.
- All returned checks are subject to a $25.00 charge in addition to your original balance.
- At our discretion, we may charge you a "No Show" fee if you fail to cancel or reschedule your appointment at least 24 hours prior to your appointment date.
- Full payment is due at the time of service. We accept cash, checks and most major credit cards.

PATIENT NAME: _____ **DATE OF BIRTH:** _____
PATIENT SIGNATURE: _____ **TODAY'S DATE:** _____

ALLIANCE WOMEN'S HEALTHCARE
DR. JONATHAN SNEAD, FACOG
& ANGELA GEORGE, WHNP
OBSTETRICS / GYNECOLOGY / INFERTILITY

ALLIANCE WOMEN'S HEALTHCARE'S NOTICE OF PRIVACY PRACTICES

Effective Date: September 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice of Privacy Practices ('Notice'), please contact:
Privacy Officer: Darla Snead, Office Manager
Phone Number: (817) 741-9663

Section A: Who Will Follow This Notice?
This Notice describes the Privacy Practices of: Jonathan C. Snead, MD PA d/b/a Alliance Women's Healthcare; and that of

Any workforce member authorized to create medical information referred to as Protected Health Information (PHI) which may be used for purposes such as Treatment, Payment and Healthcare Operations. These workforce members may include:

- All departments and units of the Provider.
- Any member of a volunteer group.
- All employees, staff and other Provider personnel.
- Any entity providing services under the Provider's direction and control will follow the terms of this notice. In addition, these entities, sites and locations may share medical information with each other for Treatment, Payment or Healthcare Operational purposes described in this Notice.

Section B: Our Pledge Regarding Medical Information
We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at the Provider. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated or maintained by the Provider, whether made by Provider personnel or your personal doctor.

This Notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- Make sure that medical information that identifies you is kept private;
- Give you this Notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the Notice that is currently in effect.

Section C: How We May Use and Disclose Medical Information About You
The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

- **Treatment.** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, health care students, or other Provider personnel who are involved in taking care of you at the Provider. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian if you have diabetes so that we can arrange for appropriate meals. Different departments of the Provider also may share medical information about you in order to coordinate different items, such as prescriptions, lab work and x-rays. We also may disclose medical information about you to people outside the Provider who may be involved in your medical care after you leave the Provider.
- **Payment.** We may use and disclose medical information about you so that the treatment and services you receive at the Provider may be billed and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about surgery you received at the Provider so your health plan will pay us or reimburse you for the procedure. We may also tell your health plan about a prescribed treatment to obtain prior approval or to determine whether your plan will cover the treatment.
- **Healthcare Operations.** We may use and disclose medical information about you for Provider operations. These uses and disclosures are necessary to run the Provider and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also

combine medical information about many Provider patients to decide what additional services the Provider should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, health care students, and other Provider personnel for review and learning purposes. We may also combine the medical information we have with medical information from other Providers to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning a patient's identity.

- **Appointment Reminders.** We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at the Provider.
- **Treatment Alternatives.** We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.
- **Health-Related Benefits and Services.** We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.
- **Authorizations Required** We will not use your protected health information for any purposes not specifically allowed by Federal or State laws or regulations without your written authorization, this includes uses of your PHI for marketing or sales activities.
- **Emergencies.** We may use or disclose your medical information if you need emergency treatment or if we are required by law to treat you but are unable to obtain your consent. If this happens, we will try to obtain your consent as soon as we reasonably can after we treat you.
- **Psychotherapy Notes** Psychotherapy notes are accorded strict protections under several laws and regulations. Therefore, we will disclosure psychotherapy notes only upon your written authorization with limited exceptions.
- **Communication Barriers.** We may use and disclose your health information if we are unable to obtain your consent because of substantial communication barriers, and we believe you would want us to treat you if we could communicate with you.
- **Individuals Involved in Your Care or Payment for Your Care.** We may release medical information about you to a friend or family member who is involved in your medical care and we may also give information to someone who helps pay for your care, unless you object in writing and ask us not to provide this information to specific individuals. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.
- **Research.** Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave the Provider. We will almost always generally ask for your specific permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the Provider.
- **As Required By Law.** We will disclose medical information about you when required to do so by federal, state or local law.
- **To Avert a Serious Threat to Health or Safety.** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.
- **E-mail Use.** E-mail will only be used following this Organization's current policies and practices and with your permission. The use of secured, encrypted e-mail is encouraged. We do not routinely check any email for medical related questions, therefore ALL medical questions must be phoned in or discussed in person.

Section D: Special Situations

- **Military and Veterans.** If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.
- **Workers' Compensation.** We may release medical information about you for workers' compensation or similar programs.
- **Public Health Risks.** We may disclose medical information about you for public health activities. These activities generally include the following:
    - to prevent or control disease, injury or disability;
    - to report births and deaths;
    - to report child abuse or neglect;
    - to report reactions to medications or problems with products;
    - to notify people of recalls of products they may be using;
    - to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and
    - to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

- **Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
- **Law Enforcement.** We may release medical information if asked to do so by a law enforcement official:
    - in response to a court order, subpoena, warrant, summons or similar process;
    - to identify or locate a suspect, fugitive, material witness, or missing person;
    - about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
    - about a death we believe may be the result of criminal conduct;
    - about criminal conduct at the Provider; and
    - in emergency circumstances, to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.
- **Coroners, Medical Examiners and Funeral Directors.** We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the Provider to funeral directors as necessary to carry out their duties.
- **National Security and Intelligence Activities.** We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- **Protective Services for the President and Others.** We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.
- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary for the institution to provide you with health care, to protect your health and safety or the health and safety of others, or for the safety and security of the correctional institution.

Section E: Your Rights Regarding Medical Information About You
You have the following rights regarding medical information we maintain about you:

- **Right to Access, Inspect and Copy.** You have the right to access, inspect and copy the medical information that may be used to make decisions about your care, with a few exceptions. Usually, this includes medical and billing records, but may not include psychotherapy notes. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.
- We may deny your request to inspect and copy medical information in certain very limited circumstances. If you are denied access to medical information, in some cases, you may request that the denial be reviewed. Another licensed health care professional chosen by the Provider will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.
- **Right to Amend.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Provider. In addition, you must provide a reason that supports your request.
- We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:
    - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
    - Is not part of the medical information kept by or for the Provider;
    - Is not part of the information which you would be permitted to inspect and copy; or
    - Is accurate and complete.
- **Right to an Accounting of Disclosures.** You have the right to request an 'Accounting of Disclosures'. This is a list of the disclosures we made of medical information about you. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the accounting (for example, on paper or electronically, if available). The first accounting you request within a 12 month period will be complimentary. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for payment or healthcare operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. In your request, you must tell us what information you want to limit, whether you want to limit our use, disclosure or both, and to whom you want the limits to apply (for example, disclosures to your spouse). We are not required to agree to these types of request. We will not comply with any requests to restrict use or access of your medical information for treatment purposes.
  You also have the right to restrict use and disclosure of your medical information about a service or item for which you have paid out of pocket, for payment (i.e. health plans) and operational (but not treatment) purposes, if you have completely paid your bill for this item or service. We will not accept your request for this type of restriction until you have completely paid your bill (zero balance) for this item or service. We are not required to notify other healthcare providers of these restrictions, that is your responsibility.

- **Right to Receive Notice of a Breach.** We are required to notify you by first class mail or by email (if you have indicated a preference to receive information by email), of any breaches of Unsecured Protected Health Information as soon as possible, but in

any event, no later than 60 days following the discovery of the breach. “Unsecured Protected Health Information” is information that is not secured through the use of a technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services to render the Protected Health Information unusable, unreadable, and undecipherable to unauthorized users. The notice is required to include the following information:

- a brief description of the breach, including the date of the breach and the date of its discovery, if known;
- a description of the type of Unsecured Protected Health Information involved in the breach;
- steps you should take to protect yourself from potential harm resulting from the breach;
- a brief description of actions we are taking to investigate the breach, mitigate losses, and protect against further breaches;
- Contact information, including a toll-free telephone number, e-mail address, Web site or postal address to permit you to ask questions or obtain additional Information.

In the event the breach involves 10 or more patients whose contact information is out of date we will post a notice of the breach on the home page of our website or in a major print or broadcast media. If the breach involves more than 500 patients in the state or jurisdiction, we will send notices to prominent media outlets. If the breach involves more than 500 patients, we are required to immediately notify the Secretary. We also are required to submit an annual report to the Secretary of a breach that involved less than 500 patients during the year and will maintain a written log of breaches involving less than 500 patients.

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or hard copy or e-mail. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice. You may obtain a copy of this Notice at our website.

To exercise the above rights, please contact the individual listed at the top of this Notice to obtain a copy of the relevant form you will need to complete to make your request.

Section F: Changes to This Notice
We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice. The Notice will contain on the first page, in the top right hand corner, the effective date. In addition, each time you register at or are admitted to the Provider for treatment or health care services as an inpatient or outpatient, we will offer you a copy of the current Notice in effect.

Section G: Complaints
If you believe your privacy rights have been violated, you may file a complaint with the Provider or with the Secretary of the Department of Health and Human Services; http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

To file a complaint with the Provider, contact the individual listed on the first page of this Notice. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Section H: Other Uses of Medical Information
Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Section I: Organized Healthcare Arrangement
The Provider, the independent contractor members of its Medical Staff (including your physician), and other healthcare providers affiliated with the Provider have agreed, as permitted by law, to share your health information among themselves for purposes of treatment, payment or health care operations. This enables us to better address your healthcare needs.

Patient Name; _____

Patient Signature Acknowledging Receipt AND Agreement to the Privacy Policies:
_____

Today’s Date: _____

Revision Date: March 03, 2013, to be compliant with HIPAA Omnibus Privacy Rules.

ALLIANCE WOMEN'S HEALTHCARE

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Phone: 817.741.9663 Fax: 817.741.3691
Jonathan Snead, M.D., F.A.C.O.G & Angela George, WHNP-BC

RELEASE OF (PHI) PROTECTED HEALTH INFORMATION

Date: _____

I, _____ (Patient Name), authorize the disclosure of my protected health information as described herein. I understand that this authorization is voluntary and made to confirm my direction. I understand that, if the person(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws, subsequent disclosure by such person(s) or organization(s) may not be protected by those laws.

I authorize Dr Jonathan C. Snead office (Alliance Womens Healthcare) to release my protected health information the following person(s)

a. Name _____ Relationship _____

Phone Number _____

b. Name _____ Relationship _____

Phone Number _____

☐ I DO NOT authorize Dr Jonathan C. Snead office (Alliance Womens Healthcare) to release my protected health information to anyone other than myself.

I understand that I may revoke this authorization in writing at any time, except to the extent that the person(s) named above have taken action in reliance on this authorization.

I have had the opportunity to read and consider the contents of this authorization. I confirm that the contents are consistent with my direction.

Patient's Printed Name: _____ DOB: _____

Patient's Signature: _____ Date: _____

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AUTHORIZATION AND RELEASE FOR INSURANCE COMPANIES AND PAYMENT

Date:_____

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or health practitioners.

I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient's Printed Name: _____ DOB: _____

Patient's Signature: _____ Date: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

TERMS OF ACCEPTANCE and DIGITAL SIGNATURE

By signing this Electronic Signature Acknowledgment Form, I agree that my electronic signature in entire packet is the legally binding equivalent to my handwritten signature. I understand that my electronic signature has the same validity and meaning as my handwritten signature. I will not, at any time in the future, repudiate the meaning of my electronic signature or claim that my electronic signature is not legally binding.

Patient's Signature: _____

THANK YOU!

We appreciate you taking the time to complete this form packet! Please select submit for form to send to directly to our secure fax.

SUBMIT