PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used for disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. 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, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPAA).

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The Patient has the right to restrict the uses of their information but the practice does not have to agree to those restrictions.
- The Patient may revoke this consent in writing at any time and all future disclosures will then cease.

I understand that:

The Practice has permission to call or contact and/or their responsible financial guarantor for treatment, payment, or health care operations. The Practice Policies include generally confirming patient appointments via phone or leaving messages on voicemail or answering machines. The Practice may call or contact patients for test, biopsy, other lab results, follow-ups, and visit reminders. In case of medical emergency or need for urgent contact, listed patient emergency contacts may be contacted.

- **I understand that all co-insurances and insurance deductibles are to be paid at the time of service.**
- **I understand that patient insurance benefits are not a guarantee of payment. Our office is dedicated to work with the patient and the insurance company to obtain all the insur ance benefits allowed. However, all charges not paid by insurance are the patient's ultimate responsibility.**
- **I understand that in addition to our fees, lab charges for lab work and biopsies to an outside source are separate charges. Patients are responsible for outside lab charges.**

This consent was signed by: ______________________________

PRINT NAME - PATIENT OR REPRESENTATIVE

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SIGNATURE DATE