Acknowledgment of Receipt of Notice and Approval of Privacy Practices

I, _____, hereby acknowledge that I have received the corresponding HIPAA Notice of Privacy Practices. I also further acknowledge and approve the uses and disclosures of my PHI as described in the HIPAA Notice of Privacy Practices.

Date: _____, 20_____ _____

Signature of Patient or Representative

Patient Contact Authorization

I, _____ (Please Print Name) authorize and give permission to (insert practice name), or any practice staff members, to leave messages regarding my medical information on the following telephone(s):

Home: ( ) _____

Cell: ( ) _____

I authorize and give permission to (insert practice name), or any practice staff member, to speak with the following people regarding my medical status and/or treatment:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Signature: _____ Date: _____

For Internal Use Only:
Scan document once after 8/1/14 into HIPAA form folder in CB

Revised 2/15

CONSENT FOR TREATMENT:
I acknowledge that I have elected on my own behalf or on behalf of my dependent to receive medical services that may or may not be covered by my health plan or any number of reasons.

I understand and acknowledge that I am financially responsible for, and therefore shall pay for, all services rendered to me or my dependent that are not paid or contractually adjusted by my insurance, in whole or in part, by my health plan for any reason whatsoever.

RELEASE OF INFORMATION:
I authorize the release of all information necessary to process my insurance claims and pertinent to my medical care. This release will remain in effect until revoked by me in writing. A photocopy of this release is to be considered as valid as the original.

ASSIGNMENT OF BENEFITS:
I assign all medical and/or surgical benefits including major medical benefits to which I am entitled, including Medicare, BCBS, HMO plans, and commercial insurance to (insert practice name) This assignment will remain in effect until revoked by me in writing. I hereby authorize the above to release information to secure payment on my behalf.

I understand that I am financially responsible for all charges. I have read this information and understand it.

Patient Name: _____

DOB: _____

Signature: _____

Signature of Parent or Guardian (if patient is a minor): _____

Date: _____

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Revised 11/15

Meridian Health Resources / Meridian Practice Institute Practices

AUTHORIZATION

PERMISSION TO RECEIVE PRERECORDED MESSAGES AND/OR TEXT MESSAGES

As a service to our patients, we provide courtesy appointment reminder calls and when we can text messages. We also may place other important calls and send text messages using a prerecorded or automated message. In order to authorize receiving the calls and messages, please fill out the information below and provide the phone number where you wish to receive these messages.

Important note: By providing your **cell phone number** below, you consent to receiving appointment reminder calls, important calls and/or text messages on your cell phone. If you would like us to utilize a different number—please provide that number below *instead of* your cell phone number.

This authorization permits us to leave messages, call or text you on the phone number that you provide below. If you provide your cell phone number, you will receive automated or prerecorded messages on your cell phone. We are required by law to advise you of this.

You do not need to sign this authorization; however, - if you do not sign this authorization, we will not be able to provide you with courtesy reminder calls, text messages or other important calls.

Patient Name: _____

Signature: _____

Signature of Parent or Guardian (if patient is a minor): _____

Phone number authorized by Patient to receive calls and message as set forth above:

Cell Phone Number: _____

Telephone Number: _____

Date: _____

For Internal Use Only:
Scan document once into Consent folder in CB

Revised 2/15