Patient Financial Information

I understand that payment in full is due at the time of service unless other arrangements have been made.

Patient Name:_____ DOB: _____

Name of insured:_____Relation_____DOB_____

Authorizations and Release:
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 other health practitioners.

I authorize and request my insurance company to pay directly to the doctor.

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.

Signature_____

HIPAA acknowledgment

I have received or was offered a notice of privacy practices.

Signature_____

Information can be released to:_____
_____

Portal Communications

Our office has set up a portal to communicate with you electronically in a secure manner. Federal regulations require our office to send you electronic communications. Please provide your email address below. This will never be shared with any third party. It will be used to send you your continuing care documents and to provide you with information regarding any diagnosis that you received.

Email address:_____

If you would like to opt out of receiving portal information please check here ☐