HOPE SURGICAL PLLC

ASSIGNMENT OF BENEFITS: I authorize my physician to release information from my medical record to my insurance carrier(s), or government agency for the processing of claims for medical benefits. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the service and pay all assigned insurance benefits directly to my physician on my behalf.

INITIALS: _____

CONSENT FOR TREATMENT: I voluntarily consent to my treatment; including physician examinations, all procedures and tests such as x-rays, blood tests, and medical treatment by the staff of HOPE SURGICAL PLLC. No guarantees have been made to the patient regarding the results of such care and treatment which are hereby authorized.

INITIALS: _____

PATIENT FIANCIAL POLICY: I understand all accounts are the full responsibility of the patient and/ or the patient's responsible party/guarantor. Please remember your medical insurance policy is a contract between you and your insurance company. We cannot be a party to the contract, Due to the policy between patient and insurance company, all copays are due at the time of service.

INITIALS: _____

PRIVACY PRACTICESS (HIPAA): I acknowledge that I have been offer a copy of HOPE SURGICAL PLLC Notice of Privacy Practices.

Accepted _____ **Declined** _____

RELEASE OF INFORMATION: I give my consent and authorization for the medical or billing staff of HOPE SURGICAL PLLC to leave protected health care information about me on my answering machine or voicemail via the telephone number I have listed below. I also consent to receive call via

Check all that apply: Phone_____ Voicemail_____ Text Message_____ Email_____

PHONE NUMBER_____ **INITIALS**: _____

PROTECTED INFORMATION: My protected health information regarding me may be shared with the following individuals:

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

INITIALS: _____

E-PRESCRIBING MEDICATIONS: I authorize my physician to fill my medications through a computerized system. I also authorize my physician to obtain my history from my pharmacy.

PHARMACY: _____ **INITIALS:** _____

SIGNATURE: _____ **DATE**: _____

PRINTED NAME: _____**REALTIONSHIP TO PATIENT**: _____