Patient Acknowledgement/Consent Form

HIPPA ACKNOWLEDGEMENT, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT

____________________	____________________	____________________
Patient's Name	Patient's DOB	Social Security Number

1. Medical Center of Frederick "Notice of Privacy Practices" provides information about how we may use and disclose protected health information about you. Please acknowledge receipt of this office Notice of Privacy Practices by Initialing (Patient Initials) __________
2. Our Notice of Privacy Practices states that we reserve the right to change the terms described. Should this happen, you will be advised. (Patient Initials) ____________
3. You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or healthcare operations. We are not required to agree to your restrictions, but if we do, we are bound by agreement with you. (Patient Initials) ___________
4. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, or healthcare operations. You have the right to revoke this content, in writing except where we have already made disclosure in trust of your prior content. (Patient Initials) ___________
5. I request that payment of authorized Medicare/Insurance carrier benefits be made on my behalf to Medical center of Frederick for any service furnished to me by Medical Center of Frederick Physicians. I authorize any holder of medical information about me to release to the Centers for Medicare/Medicaid Services and its agent and/or any other insurance carriers for which I have coverage, any information needed to determine these benefits or the benefits payable for related services. I agree to provide all referrals as required by my insurance carrier(s). All co-payments must be paid at the time of service accordance with the contracted insurances carrier agreement. (Patient Initials)__________
6. I recognize my responsibility to guarantee the accuracy of the insurance information I have provided. I agree that all claims that are not paid within 60 days because of incorrect insurance information, will become my financial responsibility. Medical Center of Frederick reserves the right to charge a service fee for any unpaid balances including co-payments and deductibles that are due at the time of service. I permit a copy of this agreement to be used in place of the original. I may revoke this agreement at any time in writing. I have read the above and fully understand it. (Patient Initials)_______________
7. I recognize that if I miss or do not show up for an appointment, I will be charged a $25.oo fee. We need a 24 hour notice of a cancellation of an appointment. (Patient Initials) ___________

Patient Signature ______________________________________ Date ________________________