PAOLI FAMILY MEDICINE

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Privacy Practices

I have read a copy of the "Notice of Privacy Practices for Paoli Family Medicine".
Paoli Family Medicine reserves the right to modify the privacy practices outlined in the notice.

Disclosure: *I give my permission to share medical information with:*

My Spouse: *Name:* _____

My Adult Child(ren): *Name:* _____

Parent(s): *Name:* _____

Other (Specify Relationship): *Name:* _____

Emergency Contact(s): *Name:* _____

Phone: _____

Message: ***You may leave detailed medical information*** *on my answering machine or voice mail at the* ***phone number*** *listed below.*

Phone: _____

Agreement with Privacy Practices

_____ *Birthdate:* _____
Name of Patient (Print)

_____ *Date:* _____
Signature of Patient (or Patient Representative)

_____
Printed name and relationship of patient representative (required if patient is a minor or an adult who is unable to sign this form).

If you would like to set up an account to have access to your electronic records we need an ***E-mail address.***

E-mail address: _____

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Information Booklet

I have received the Paoli Family Medicine Information Booklet containing information about patient privacy, additional fees, appointments, referrals, telephone hours and sick visits.

_____ *Date:* _____

Signature of Patient (or Patient Representative)

*Declined Information Booklet:*_____ *Date:* _____

Insurance Agreement

- *I authorize any holder of medical or other information about me to release this information to my insurance company, its intermediaries or carriers, to my attorney or another physician's office.*
- *I hereby authorize direct payment of the medical benefits to which I am entitled from Medicare, private insurance and/or any other health plan to Paoli Family Medicine.*
- *I permit a copy of this authorization to be used in place of the original. This assignment will remain in effect until revoked by me in writing.*
- *I understand that I am financially* responsible *for all charges, including those remaining after insurances have been billed.*

I have read and understand the above insurance information.

*Signature:*_____ *Date:* _____

*Patient Name:*_____ *Date:* _____

Uninsured

I understand that if I ***do not*** *have insurance, I am fully responsible for payment of fees at time of service.*

*Signature:*_____ *Date:* _____

Medicare Waiver (Medicare Patients Only)

If Medicare denies payment, I agree to be personally and fully responsible for payment.

Medicare *will only pay for services it determines to be "reasonable and necessary" under Section1862(a)(1) of the Medicare law.* ***If*** *Medicare determines that a particular service is not "reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service. Patients need to be aware that Medicare may deny payment for one or more of the following procedures:*

Annual Physical Pulse Oximetry Peak Flow EKG PAP Preventive Immunization

I have read and understand the above insurance information.

Signature: _____ Date: _____

Patient Name: _____ Date: _____