## PERMISSION FOR TREATMENT

Permission is granted to Navnit U. Patel, MD. PA, to administer Medical and/or Surgical treatment deemed advisable and necessary in the diagnosis and treatment of the patient's condition.

SIGNATURE: _____ DATE: _____
(Signature of Parent if minor)

## AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I hereby authorize Navnit U. Patel, MD. PA to furnish information to insurance carriers concerning my illness and treatment.
I hereby assign to Navnit U. Patel, MD PA/physicians all payments for medical services rendered to myself or my dependents.

I understand and agree (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I understand that I am responsible for any charges incurred if my account is sent to a collection agency and for returned checks. I **agree to take full responsibility for any unpaid balances and that such payment will be made to this office for services rendered.** I certify that the information I have given here is true and correct to the best of my knowledge. I will notify you of any changes in my status or above information.

SIGNATURE: _____ DATE: _____
(Signature of Parent if minor)

## DESIGNATED RELATIVE

I authorize discussion and release of my general Medical condition and diagnosis (including treatment, payment and hospital care) to the persons below:

Name: _____ (Relationship) _____ Phone: _____

SIGNATURE: _____ DATE: _____
(Signature of Parent if minor)

**I agree to call the office 24hrs in advance for any cancellation of appointment. I understand that I will be charged $25 for no show.**
Messages may be left on my answering machine regarding my Health and appointment: ( ) yes ( ) No

## PRIVACY NOTICE

WE ARE REQUIRED BY LAW TO MAINTAIN THE PRIVACY OF, AND PROVIDE INDIVIDUALS WITH NOTICE OF OUR LEGAL DUTIES AND PRIVACY PRACTICES WITH RESPECT TO PROTECTED HEALTH INFORMATION.

IF YOU HAVE ANY OBJECTIONS TO THE NOTICE, PLEASE ASK TO SPEAK WITH OUR HIPPA COMPLIANCE OFFICER IN PERSON OR BY PHONE AT OUR MAIN OFFICE NUMBER.

SIGNATURE BELOW IS TO ACKNOWLEDGE THAT YOU HAVE READ AND RECEIVED THIS NOTICE OF OUR PRIVACY PRACTICES.

PRINT NAME: _____

SIGNATURE: _____ DATE: _____