David Wolff MD PLLC **Phone: 712-266-3033** **Fax: 515-666-8960**
19564 C16
Akron, IA 51001

Acknowledgement of Privacy Notice/Condition of Tx

Please check

☐ **FOR FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS** I hearby assign all payments for medical/surgical services rendered by David Wolff MD, PLLC including Medicare, private insurance and other healthcare coverage to David Wolff MD, PLLC. This assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges, including any amount not covered by my insurance company. I authorize David Wolff MD, PLLC to furnish medical information necessary to process insurance claims for me or my covered dependents.

Please check

☐ **RECORDS RELEASE FOR CLAIMS PAYMENT** I authorize direct payment of medical/surgical benefits to David Wolff MD, PLLC. for the services rendered to me. I authorize the release of medical record information to any insurance company that may be necessary for verifying the services rendered and obtaining payment of the account. I understand that execution of this authorization waives my right of confidentiality as to the material released pursuant to this authorization. My signature below represents that I have read and understand the terms above. This authorization shall remain in effect unless revoked by me in writing and may not be revoked as to services rendered prior to my notice of revocation.
A photocopy of this notice is as valid as the original.

Please check

☐ **CONSENT TO TREAT** I, the undersigned, hereby voluntarily authorize the attending healthcare provider and/or his/her assistant, David Wolff MD, PLLC. and its employees to administer any x-ray examination, laboratory studies, medical or minor surgical diagnosis, treatment and service that are deemed advisable. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me about the curative value of such examination, or treatment on my condition.

Please check

☐ **WIRELESS COMMUNICATIONS** I hereby agree that by providing my wireless/cell phone number, I am, granting my consent to receive calls and or texts on my wireless/cell phone number for any business related to my healthcare services or payment thereof. Methods of contact may include using voice messages, text messages, as applicable.
If you choose to no longer consent to wireless communication please text the word "STOP" to opt out at any time of text messaging.

Please list in the space below the names, relationship of family members or other persons and phone numbers, if any, whom we may inform about your general medical condition and your diagnosis: including treatment, payment, and healthcare operations: You may list as many names as you wish.

_____

Name/Relationship/Phone#

_____

Name/Relationship/Phone#

_____

Name/Relationship/Phone#

_____

Name/Relationship/Phone#

I acknowledge that I have been given the opportunity to read the Notice of Privacy Practices for David Wolff MD, PLLC. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. David Wolff MD, PLLC reserves the right to modify the privacy practices outlined in the notice. The statement of Privacy Notice can be found on our web site at www.wolffmd.com.

Signature:_____ Date: _____