Creekside Medical Clinic Privacy/Billing/Sharing Procedures Authorization and Acknowledgement

Name: _____Birth Date: _____

Gender: _____Marital Status: _____

Home Address: _____

Cell: _____Email: _____

Emergency Contact Name/Phone Number: _____

Insurance/Subscriber ID/Grp ID: _____

Responsible Party Name and Phone number: _____
(IF OTHER THAN PATIENT)

These authorizations / acknowledgements cover all services rendered to the above patient for today and all future dates of service. You may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any events that occurred before you notified us of your decision to revoke.

Acknowledgement of receipt of notice of privacy practices: We reserve the right to modify the privacy practices outlined in the Notice of Privacy Practices. I have received a copy of the Notice of Privacy Practices for the patient outlined above.

Authorization to Treat and Bill: I give consent for the patient to be treated by Creekside Medical Clinic and its physicians. I authorize the release of any medical and demographic information necessary to process all claims. I authorize payment of medical benefits to Creekside Medical Clinic for all services performed and billed by Creekside Medical Clinic. Creekside Medical Clinic will submit a claim for services rendered to my insurance carrier and do so as a courtesy.

I understand that if I do not provide complete and accurate billing/insurance information at the time of service and this prevents Creekside Medical Clinic from collecting from my insurance company, I will be responsible for the full charges. I understand I will be held responsible for any balance that remains on the account after the insurance company has paid according to contract including services that my insurance company considers non-contracted, non-covered or preventative.

It is my understanding that Creekside Medical Clinic will send lab specimens to an outside laboratory. I give permission for those outside laboratories to bill my insurance for their services. I understand that I may incur additional charges as a result of those outside laboratory tests. I understand that Creekside Medical Clinic is not responsible for payment to those laboratories. I understand that if my account remains unpaid, it will be sent to collections and collection costs of up to 35% or $20, whichever is higher will be added to the account balance and become my responsibility.

Signature: _____Date: _____

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Name of Patient Representative Signing for Patient and Relationship to Patient (Required if the patient is a minor or an adult who is unable to sign this form)

Name and relationship of people with whom your information can be shared