FLORIDA MOBILE PHYSICIANS, LLC
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Consent to Receive Psychological Services, Assignment of Benefit, HIPPA, and Financial

Patient Name:_____ **Date of Birth:**_____ **Marital Status:**_____

Facility:_____ **Room Number:**_____

Facility Provider/Credentials:_____ **License #:**_____ **Date:**_____

CONSENT TO RECEIVE PSYCHOLOGICAL SERVICES AND ASSIGNMENT OF BENEFITS

_____I fully understand that I am giving my consent to receive psychological services.
_____I agree that these services are mutually understand to be appropriate, and that I may withdraw my consent at any time.
_____I authorize Dr. Ronald Droz to obtain and release information regarding my treatment to any care provider/family member who presents a valid need for such information as determined by the provider.
_____I authorize release of medical information necessary to process claims for services rendered on my behalf. For these services, I authorize payment directly to Dr. Ronald Droz by Medicare, health insurances, or third party benefits. Provider of services accepts assignments.

CONSENT TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

As a condition of providing treatment to you, Dr. Ronald Droz may request your consent to use and disclose health information about you to carry out treatment, payment, and health care operations.
You may revoke this consent at any time by notifying Dr. Ronald Droz in writing, except to the extent that the provider has taken action and reliance on your consent.
Please refer to the Notice Of Privacy Practices For Protected Health Information ("Private Notice") for a more complete description of the uses and disclosures that Dr. Ronald Droz may use of your protected health information.
You have the right to change its privacy practices described in this Privacy Notice. In accordance with the law, the terms of the Privacy Notice may change. At any time, you may obtain a copy of the current Privacy Notice and any revised notice.
You have the right to request that Dr. Ronald Droz restrict the manner in which protected health information is used or disclosed to carry out treatment, payment, or health care operations. The provider is not required, however, to agree to such requested restrictions. If, however, the provider agrees to the requested restriction, the provider will honor the request and it will be binding.
_____I hereby consent to the use and disclosure by my provider, its workforce, and its business associates of my protected health information for purposes of treatment, payment, and health care operations.

FINANCIAL CONSENT

Dr. Ronald Droz accepts assignment. The patient will be responsible for any amount not covered by insurance.
The patient understands his/her responsibility: ___ **YES** ___ **NO**
Financially able to make co-payment (if any): ___ **YES** ___ **NO**
Kindly accept a photocopy or facsimile of this authorization as if it were an original authorization.

I understand that my signature below will act as a signature on file.

_____ **Date:**_____

___ ***Patient*** ___***Guarantor/POA*** ___ ***Witness***

Print Name/Title: _____ **Phone #:**_____