SIGNATURE AND AUTHORIZATION FORM

Medicare Patients
By signing below I acknowledge that I have received a copy of the Medicare authorization policy included in the Office Policies and understand it.

_____ _____
Signature (Patient or Authorized Representative) Date

Consent for Treatment.
By signing below I acknowledge that I have received a copy of the Consent for Treatment policy included in the Office Policies and understand it.

_____ _____
Patient (or Guardian) Signature Date

Photo Consent
By signing below I acknowledge that I have received a copy of the Photo Consent policy included in the Office Policies and understand it and I agree to have my photo taken. If photo is refused please initial here_____.

_____ _____
Patient (or Guardian) Signature Date

E-Mail Consent
Do you have an E-mail address that you are willing to give to our office for medical use? Yes or No.
If so what is your e-mail address: _____

HIPPA also requires us to address any special needs you may have to assure your patient information is kept confidential. You may request a detailed description of this policy to keep for your records if needed.

May we leave a message on your answering machine if you are not available? PLEASE CIRCLE ONE…
Yes No
May we leave results of any diagnostic test on your answering machine if you are not available?
Yes No
May we call you at work with test results or other health related issues?
Yes No If so, what is your work number? _____
May we leave messages on your voice mail for cellphone or other phone?
Yes No Phone number: _____

Other than yourself, do you authorize our office to discuss your health information with any other person(s): (For example, your spouse, child or parents.) If so, please list names below for our record. **If you do not list someone on this release, we cannot give out any information to ANYONE even in the event of an emergency.**

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Do you have a living will or durable Power of Attorney? ____ yes ____ no
If you do have a durable power of attorney, please identify who is responsible for this. _____.
If not would you like information on how to obtain an advance directive? _____ yes _____ no.

By signing below I acknowledge that I have been offered a copy of the 2 PAGE office policies to take with me and I have read these policies and understand them.

_____ _____
Signature (Patient or Authorized Representative) Date