THE COSMETIC VEIN & LASER CENTER

PATIENT AUTHORIZATION AND ACKNOWLEDGEMENT OF PRACTICE'S FINANCIAL AND PRIVACY POLICY

In general, the HIPAA Privacy Rule (Health Insurance Portability and Accountability Act of 1996 – a federal law) gives individual the right to request a confidential communication between and individual and his/her physician's office.

In order to protect your privacy and in keeping with the Federal Privacy Law, all of your medical information, PHI, is kept strictly confidential. We will use this PHI for Treatment, Payment, and Operation (TPO) of our medical practice. We will be required to get an authorization in writing from you if we intend to use your PHI for any other purposes.

AUTHORIZATION

I authorize the release of any PHI necessary to determine liability for payment and to obtain reimbursement on any claim.

I request that payment of authorized surgical and medical benefits be made on my behalf. I assign benefits payable to which I am entitled, including, but not limited to, Medicare, private insurances, and other health management organizations to the practice named on this form.

The assignment of benefits will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. Any applicable collection fees will be added to the unpaid balance that necessitates the use of a collection agency.

I authorize The Cosmetic Vein & Laser Center to leave medical or cosmetic information pertaining to my care by the following methods; and I will assume the responsibility of notifying the office whenever this information changes. Please indicate below how you would like our office to handle communications with you:

Permission to contact me or leave a detailed message via:

Home	_____ yes	_____ no
Cell	_____ yes	_____ no
Work	_____ yes	_____ no
Text	_____ yes	_____ no
Email	_____ yes	_____ no

Persons authorized to receive my information:

☐ **MYSELF ONLY**

☐ **THE FOLLOWING PERSONS:**

1._____

2._____

3._____

☐ **THE FOLLOWING PHYSICIANS:**

1. Primary Care Physician: _____

2. Other Physician: _____

I agree to the insurance assignments and my financial responsibilities as indicated by The Cosmetic Vein & Laser Center. I am also aware of my rights and the practice's responsibilities with respect to Private Health Information (PHI) as outlined in The Cosmetic Vein & Laser Center's Notice of Privacy Practices.

_____ _____

Patient Name (Please Print) Date

_____ _____

Signature (Patient or Parent if Minor) Date