

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I CERTIFY THAT I HAVE READ AND RECEIVED NOTICE OF PRIVACY PRACTICES AND THAT ALL MY QUESTIONS REGARDING THE HIPPA HAVE BEEN ANSWERED AS THEY PERTAIN TO MY PROTECTED HEALTH INSURANCE (PHI)

IRREVOCABLE AUTHORIZATION AND ASSIGNMENT OF BENEFITS

1. You are authorized to release information within your guidelines concerning my health condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred with Rajesh Patel, MD.
 2. I hereby assign the direct payment to you of any sum I now or hereafter owe you and authorize my attorney out of the proceeds of any settlement or other distribution of funds to me, and by any insurance company obligated to reimburse me for the charges made for your services.
 3. In the event any insurance company obligated to make payment to me or to you for the charges made for your services refused to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such insurance company and authorize you to enforce that action either in my name or your name as may be appropriate and further authorize you to compromise, settle, or otherwise resolve said claim as you deem to be in your best interest. However, it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company who may be contractually obligated, you will refrain from attempts and efforts to collect the amounts owed directly to me. I understand that whatever amounts you do not collect from insurance proceeds or from settlement or from other sources, I personally owe to you.
 4. I recognize that there may be a time delay between the rendering of services by you and the collection of such amounts. As such, I waive the applicable Statute of Limitations as to enforcing any such claim or other right as created by this agreement.
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OFFICE POLICIES WE WOULD LIKE YOU TO BE AWARE OF:

Co-pays are due at the time of visit upon registration. Please do not wait until the conclusion of the appointment to present the copay. We are trying to trim billing costs.

You must notify us of the correct insurance and have valid referrals. Due to regulations of your insurance company, this office cannot see you without a valid referral and you will have to assume responsibility for all expenses that occur for miscalculations with insurance. We cannot process referrals when patients arrive at the office, they must be obtained and authorized prior to the visit. Please be very familiar with your coverage.

SIGNATURE OF PATIENT: _____

PRINT PATIENT NAME: _____

DATE: _____