LIFECARE MEDICAL ASSOCIATES, PC

RECEIPT OF PRIVACY NOTICE

_____ I have received the privacy notice.

_____ I have declined to receive the privacy notice.

CONSENT FOR TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

I consent to have this Practice use and disclose my protected health information for payment, treatment, and healthcare operations, and for such other purposes that are permitted under HIPAA regulations without written authorization.

I understand and agree that (regardless of my insurance status) I am ultimately responsible for any balances on my account for all professional services rendered.

I request that payment of authorized benefits be made either to me or on my behalf to Lifecare Medical Associates, PC or Lifecare Medical Diagnostics, Inc. for any services furnished me by that physician or facility.

I authorize any holder of medical information about me to be released to any appropriate insurance company and its agents any information needed to determine these benefits or the benefits payable for related services.

_____

PATIENT NAME - PRINTED DOB

_____

PATIENT/PARENT/GUARDIAN SIGNATURE DATE

<u>DISCLAIMER</u>: FAILURE TO SIGN THIS FORM WILL DISCONTINUE SUBMISSION OF CLAIM(S) TO APPROPRIATE INSURANCE COMPANY AND PATIENT WILL BE RESPONSIBLE FOR PAYMENT AT TIME OF SERVICE.