FAMILY PRACTICE CENTER OF WADSWORTH, INC.

Authorization for Treatment, Assignment of Benefits & Information Release

I hereby request and consent to treatment and services reasonable and proper by today's standards provided by a physician of Family Practice Center of Wadsworth, Inc. and authorize payment directly to the physician of the Medical and/or Surgical benefits, if any, otherwise payable to me by Medicare or any other insurance company, for his/her services, and I assume responsibility for any unpaid balance including non-covered services except as limited by law. I also hereby authorize the physician to release any information to a Health Care Financing Agency, or its agents, to third party payers and anyone assisting the provider in obtaining payment including billing, coding, and collection agents, provider's attorney, consultants, and to my insurance company as acquired in the course of my examination or treatment. This authorization will remain in effect until revoked by me in writing.

I have reviewed and accepted the above Authorization, Assignment and Information Release.

_____ _____

Signature of Patient/Responsible Party **Minor's Name**

_____ _____

Printed Signed Name **Date**

Receipt of Notice of Privacy Practice/Written Acknowledgement Form

I, _____, have been offered and made available a copy of Family Practice Center of Wadsworth, Inc. Privacy Practices. I know I may receive a copy at any time, including any revisions.

_____ _____

Signature of Patient/Responsible Party **Date**

☐ Patient unable to sign due to: _____

☐ Patient refused to sign.

_____

Date

☐ I authorize my protected health information to be disclosed to the following person(s). I understand I can revoke this authorization in writing at any time.

☐ I do not authorize my protected health information to be disclosed to anyone except those required by law that is stated in the privacy policy.

1. _____ _____

Name of Person **Relationship**

2. _____ _____

Name of Person **Relationship**

3. _____ _____

Name of Person **Relationship**

_____ _____

Signature of Patient/Responsible Party **Date**

Our Financial Policy

I have received a copy of the Financial Policy. I have reviewed and accepted the Financial Policy.

_____ _____

Signature of Patient/Responsible Party **Minor's Name**

_____ _____

Printed Signed Name **Date**