

# ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below I acknowledge that I have reviewed or received a copy of this office's Notice of Privacy Practices Form.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

## Documentation of Failure to Obtain Signed Acknowledgment

On \_\_\_\_\_, 20\_\_\_\_ presented this Acknowledgment of Receipt of Notice of Privacy Practices Form to \_\_\_\_\_ (the "Patient"). The Patient refused to provide a signature when requested.

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## CONSENT FOR USE AND DISCLOSURE OF YOUR HEALTH INFORMATION

Our purpose in asking you to sign this form is to document that we have informed you that this office may use and disclose all your health information in our possession (collectively "Protected Health Information").

The uses and disclosures by this office of your Protected Health Information are necessary and will be used by this office in connection with your treatment, our obtaining payment for treatment and services that this office provides to you and so that this office can conduct its health care operations.

For a more complete description of how this office may use and disclose your Protected Health Information, please carefully review the Notice of Privacy Practices Form that this office has prepared and is furnishing to you today. Please also see our Notices of Privacy Practices Form for a more detailed discussion of the meanings of "treatment", "payment", and "health care operations".

**YOU HAVE THE RIGHT TO REVIEW OUR NOTICE OF PRIVACY PRACTICES FORM PRIOR TO SIGNING THIS CONSENT. PLEASE BE ADVISED THAT THE NOTICE OF PRIVACY PRACTICES FORM MAY BE REVISED BY THIS OFFICE FROM TIME TO TIME. ANY**

**YOU SHOULD ALSO REVIEW CAREFULLY THE NOTICE OF PRIVACY PRACTICES FORM BECAUSE IT CONTAINS A LIST OF RIGHTS THAT ARE AVAILABLE TO YOU WITH RESPECT TO THIS OFFICE'S USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION. THESE RIGHTS INCLUDE YOUR RIGHT TO REQUEST RESTRICTIONS ON OUR USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION.**

**YOU HAVE THE RIGHT TO REVOKE THIS CONSENT AT ANY TIME. IF YOU WISH TO REVOKE THIS CONSENT, YOU MUST DO SO IN WRITING.**

**BY SIGNING BELOW, YOU ACKNOWLEDGE THAT YOU HAVE READ AND UNDERSTAND THIS CONSENT AND THIS OFFICE'S NOTICE OF PRIVACY PRACTICES FORM. YOU FURTHER ACKNOWLEDGE THAT YOU HAVE RECEIVED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES FORM TO TAKE WITH YOU.**

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

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**Insurance Authorization and Assignment:** I hereby assign, to Einas Joseph MD PC payment of medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization.

**Financial Agreement:** I understand that I am financially responsible for all charges whether or not they are covered by my insurance as well as any co-payment and co-insurance. In the event of non-payment for any of these costs, I understand I will be legally responsible for all costs involved with the collection of this account including all court costs, attorney fees, and any expenses incurred, should this be required.

**Consent to Treat:** I request and give consent to my physician to provide and perform such medical/surgical care, tests, drugs and other services and supplies as are considered necessary or beneficial by my physician for my health and well being. I acknowledge that no representations, warranties or guarantees as to the result or cures have been made to me or relied upon by me.

**Medicare Certification:** I request that payment of authorized Medicare benefits be made either to me or on my behalf to EINAS JOSEPH MD PC for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.  
I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

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**TELEPHONE CONSUMER PROTECTION ACT OF 1991**

By signing this document, I agree, in order for EINAS JOSEPH MD PC. to service my account or to collect any amounts I may owe, and its third party billing and/or debt collection service providers may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which may result in charges to me. Additionally, I authorize contact via text messages or emails, using any email address I provide. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, if applicable.

I/We have read this disclosure and authorize express consent that Einas Joseph MD \ Oakland General Surgery and its affiliates and third party service providers may contact me/us as described above.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_