MARK S BRIGHAM D.O., INC.

Authorization for Treatment, Assignment of Benefits & Information Release

I hereby request and consent to treatment and services provided by a physician, technician, or nurse of Mark S. Brigham, D.O., Inc. I hereby authorize release of information necessary to file a claim with my Insurance Company and assign unpaid benefits otherwise payable to me to Mark S. Brigham D.O., Inc. I understand I am financially responsible for all charges whether or not paid by insurance. A copy of this signature is as valid as the original. I understand this office uses answering machine/voicemail/email for messages and/or automated calling systems for appointment reminder calls.
My signature below gives my authorization to release medical records to other physician practices or facilities that I am being referred to by Mark S. Brigham, D.O. and to physician practices or facilities that I have been referred from for treatment and services by Mark S. Brigham D.O.
I acknowledge that I have access to the PRIVACY NOTICE of Mark S. Brigham D.O., Inc. and am aware of the HIPAA Privacy Standards.

Our Financial Policy

I have read the Financial Policy, Office Policies, and/or Uninsured Policy and agree to them as outlined. By signing below I agree to all the terms as listed. I understand that I may receive a copy of these policies at any time upon request. I agree to pay any and all fees for not showing for a scheduled appointment, cancelling a scheduled appointment in less than 24 hours, and for not paying my copays at the time of service as outlined in the Financial Policy.

❒ I am **uninsured** and understand I am responsible to pay in full at the time services are rendered. If I am unable to pay in full and would like to request payment options, I understand arrangements must be made in advance of my appointment by calling the billing department at (330) 336-8717 option 2.

Receipt of Notice of Privacy Practice

I acknowledge that I have access to the PRIVACY NOTICE of Mark S. Brigham D.O., Inc. and am aware of the HIPAA Privacy Standards. I understand that I may receive a copy at any time upon request. I understand the office has 30days to fill this request. I acknowledge that I was offered and/or given a copy of the Privacy Policy for Mark S. Brigham D.O., Inc.
Your Authorization: We will not use or disclose your protected health information (PHI) for any purpose unless you have signed a form or provided electronic signature authorizing the use or disclosure. You have the right to revoke that authorization in writing unless we have taken any action in support on the authorization.

❒ I authorize my protected health information to be disclosed only to the following person(s). I understand I can revoke this authorization in writing at any time. *(Please list names below)*
❒ 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 Date

2. _____ _____
Name of Person Date

3. _____ _____
Name of Person Date

- - - Please Sign Below - - -

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

_____ _____
Printed Name **Date**