
Kentlands Medical Associates
PATIENT ACKNOWLEDGMENT/CONSENT FORM
HIPAA Acknowledgment, Assignment of Benefits, Financial Agreement

Patient's Name (please print)

Patient's DOB

Medicare# (If Appl.)

Patient's ID #

1. Kentlands Medical Associates' "Notice of Privacy Practices" provides information about how we may use and disclose protected health information about you. Please **acknowledge receipt** of this office's "Notice of Privacy Practices" by initialing:

(Patient's Initials)

2. Our notice of Privacy Practices states that we reserve the right to change the terms described. Should this happen, you will be advised.

(Patient's Initials)

3. You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree to your restrictions but if we do, we are bound by our agreement to you.

(Patient's Initials)

4. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent.

(Patient's Initials)

5. I request that payment of authorized Medicare/Insurance carrier benefits be made on my behalf to Kentlands Medical Associates for any service furnished to me by Kentlands Medical Associates' physicians. I authorize any holder of medical information about me to release to the Centers for Medicare/Medicaid Services and its agent and/or any other Insurance Carriers for which I have coverage, any information needed to determine these benefits for the benefits payable for related services. I agree to provide all referrals as required by my insurance carrier(s). All co – pays must be paid at the time of service in accordance with the contracted Insurance Carrier agreements.

(Patients Initials)

6. I recognize my responsibility to guarantee the accuracy of the insurance information I have provided. I agree that all claims that are not paid within 60 days because of incorrect insurance information will become my financial responsibility. Kentlands Medical Associates reserves the right to charge a service fee for any unpaid balances including co – pays and deductibles that are due at the time of service. I permit a copy of this balance to be used in place of the original. I may revoke this agreement at any time in writing. I have read the above and fully understand it.

Patient's Signature

Date