Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medical Record No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:*

I, the undersigned, have been offered a copy of Midwest Regional Allergy Asthma Arthritis & Osteoporosis Center’s *Notice of Privacy Practices (“Notice*”), which describes how my health information is used and shared. I understand that Midwest Regional Allergy Asthma Arthritis & Osteoporosis Center has the right to change this *Notice* at any time. I may obtain a current copy by contacting the Office Privacy Official, or by visiting the Midwest Regional Allergy Asthma Arthritis & Osteoporosis Center web site at [www.michaelejosephmd.com](http://www.michaelejosephmd.com)

**My signature below acknowledges that I have been provided with a copy of the *Notice of Privacy Practices:***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Personal Representative Print Name Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Personal Representative’s Title (e.g., Guardian, Executor of Estate, Health Care Power of Attorney)

**For Office Use Only: Complete this section if you are unable to obtain a signature.**

1. If the patient or personal representative is unable or unwilling to sign this *Acknowledgement*, or the *Acknowledgement* is not signed for any other reason, state the reason:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Describe the steps taken to obtain the patient’s (or personal representative’s) signature on the *Acknowledgement:*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Completed by:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Office Representative Print Name Date

Authorization for Treatment:

\_\_\_\_\_I, the undersigned patient and /or responsible relative or legal guardian, hereby consent to allow physicians, other healthcare providers, and medical/nursing personnel of Midwest Regional Allergy, Asthma, Arthritis, and Osteoporosis Center, to administer and perform all medical examinations, diagnosis, treatments and procedures which are deemed medically necessary and for which the patient or legal guardian voices no specific objections. I understand that medicine is not an exact science and that no guarantee or assurance has been made as to the results which may be obtained.

Authorization for Financial Arrangement and Payment:

\_\_\_\_\_All charges not covered by insurance are due in full at the time of service. The undersigned assumes financial responsibility for examinations, treatment, procedures and all other services provided. Any other arrangements must be made prior to care and noted by the receptionist. If there are any defaults with any arrangements made and the account is turned over to a collection agency, all fees associated with that collection agency will be the responsibility of the undersigned. I authorize direct payment of all medical benefits to Midwest Regional Allergy, Asthma, Arthritis and Osteoporosis Center and agree upon demand to pay said facility whatever sum of money that may become due on this account. I have been offered a copy of the Financial Policy.

Authorization for Release of Information:

\_\_\_\_\_I authorize the release of information to the financial party, insurance company, or federal/state payer as appropriate for billing and receiving payment for any and all medical services provided by Midwest Regional Allergy, Asthma, Arthritis, and Osteoporosis Center, PC.

Authorization for Medicare and Medicaid Billing:

\_\_\_\_\_I certify that all information given is true and correct to the best of my knowledge and to be used for payment under Title XVIII and Title IX of the Medicare and Medicaid Billing Requirements Act and that no other payment source should be billed prior to the submission of this claim to a federal payer. The showing of a Medicare or Medicaid card shall serve as representation the above listed patient is indeed an eligible beneficiary of the program being billed for above said medical services. I agree to be responsible for any and all charges should this not be the case.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient or legal guardian Printed Name of patient or legal guardian Date

File original in patient's Chart: Registration Information.