

# Michiana Hematology Oncology, PC

**By my signature below, I understand and agree to the following:**

- H.H.S.: Pursuant to the Health Insurance Portability and Accountability Act of 1996, I acknowledge that I have received a copy of NOTICE OF PRIVACY PRACTICES.
- CONSENT TO TREAT: I request and give consent to my physician to provide and perform such medical/surgical care, tests, procedures, 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 results or cures have been made to me or relied upon by me.
- RELEASE OF MEDICAL INFORMATION AND AUTHORIZATION TO PAY INSURANCE BENEFITS: I authorize my physician to release information from my medical record to my insurance carrier(s), or government agency, for the processing of claims for medical benefits. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to my physician on my behalf.
- MEDICARE CERTIFICATION: I certify the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize my treating physician to release information from my medical record to the Social Security Administration and/or Medicare program or its intermediaries or carriers. I request that payment of authorized benefits be made directly to my treating physician on my behalf.
- FINANCIAL AGREEMENT: I understand that I, or my responsible party/guarantor, am wholly responsible for payment of my account balance. My physician will assist me in obtaining insurance benefits when those benefits are assigned to my physician. It is my responsibility to make sure insurance payments are processed and paid promptly to my physician. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.
- RELEASE OF PROTECTED HEALTH CARE INFORMATION VIA TELEPHONE TO ANSWERING MACHINE OR VOICE MAIL: I give my consent and authorization for the medical or billing staff of my physician's office to leave Protected Health Care Information about me, or for me, on my answering machine or voice mail at this telephone number (\_\_\_\_\_). I understand I may revoke this privilege at any time by submitting my request in writing to this office.

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

Parent/Guardian (if minor) \_\_\_\_\_ Date \_\_\_\_\_