PATIENT CONSENT & HIPAA FORM

Patient name: ____Date of Birth: _____________________

AUTHORIZATION FOR FAMILY/OTHERS REGARDING MY CARE:

I authorize Fox Valley Pulmonary Medicine (FVPM), to communicate with the following person(s) regarding appointments, diagnosis, care, treatment, procedures, results and billing questions related to my care:

Name: ________________________________ Phone: _________________Relationship: ______________

Name: ________________________________ Phone: _________________Relationship: ______________

Name: ________________________________ Phone: _________________Relationship: ______________

If I am unavailable, I authorize FVPM to leave messages regarding medical matters at (   )________-__________ or (   )__________- ______________.

I understand that the release of copies of my medical records requires a specific authorization form signed by myself or my legal representative. This form shall remain in effect until changed or revoked by me in writing.

Signature: ____ Date: _________________________

(Patient or person legally authorized to sign for patient)

Printed Name: ____

CONSENT FOR CARE: I understand that by signing this document, I consent to all general outpatient medical care and/or routine outpatient services, including evaluation, therapies, nursing care and diagnostic testing provided under the general or specific instruction of my physician(s) and other health care providers.

SIGNATURE FOR PAYMENT: I request that payment of authorized insurance benefits be made to Fox Valley Pulmonary Medicine for services provided to me. I give permission to FVPM to release medical information regarding my care to insurance companies for the purpose of deciding benefits and processing claims. I agree to be responsible for charges not covered by insurance.

I understand it is my responsibility to provide FVPM with accurate insurance information. It is also my responsibility to obtain any required referrals or pre-authorizations required by my insurance company. Copayments are required by some insurance carriers and are to be made at the time of service. I agree to pay for services provided to me or my family member.

I acknowledge that there is a Notice of Privacy Practices available for me to read and receive copy of upon request.

By signing this form, I acknowledge my understanding and agreement with the above printed content.

Signature: ____________________________________Relationship: ______________ Date:______________

Patient or person legally authorized to sign for patient