

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign

(Name of Insurance Company(ies))

directly to Dr. _____ all insurance benefits, if any otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

Relationship

Date

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have been notified that a copy of SURGICAL PRACTICE'S LTD, Notice of Privacy Practices is available. The Notice contains information regarding potential uses and disclosures of my protected health information (as that term is defined under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")) that may be made by the Practice, and of my rights and the Practice's legal duties with respect to my protected health information. I have had the opportunity to review the Notice and take a copy with me if I so choose.

Patient's Name

Patient's Signature

Date

Disclosure Authorization:

I give permission that Surgical Practice, LTD, may:

- Leave a detailed message on my home answering machine or voice mail
- Leave a verbal detailed message with my spouse
- Call my workplace phone number and leave a message
- Call my workplace phone number and speak to me only
- May discuss my condition(s) with _____
- None of the above