SOUTH TABOR
FAMILY PHYSICIANS LLP

Patient name: _____ Date of birth: _____

Acknowledgment and Consent

I understand that South Tabor Family Physicians LLP (STFP) will use and disclose health information about me.

I understand that I have been provided with the STFP's Notice of Privacy Practices and Breach Notification Policy. The Notice of Privacy Practices and Breach Notification Policy describes the types and of uses and disclosures of my protected health information. My protected health information may include information both created and received by STFP, and it may be in the form of written or electronic records or spoken words and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, payments and similar types of health related information.

I understand that the Notice of Privacy Practices and Breach Notification Policy may be changed at any time. I also understand that a copy of the most current version will be posted in the waiting room, and I can ask for a copy anytime. I understand that I have the right to ask that some or all of my protected health information not be used or disclosed in the manner described in the Notice of Privacy Practices and Breach Notification Policy, and I understand that STFP is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices and Breach Notification Policy.

Conditions of Treatment and Assignment of Benefits

Consent to treatment: I authorize the administration and performance of all diagnostic procedures and treatment determined by the judgment of my provider to be considered necessary or advisable.

Release of Information: STFP will obtain written permission from the patient to release information except in those circumstances when STFP is permitted or required by law to release information. I agree that to determine liability for payment and to obtain reimbursement the clinic may disclose portions of my records to any person or corporation which is or may be liable for all or any portion of the charges, including but not limited to insurance companies, health care service plans or worker's compensation carriers. Special permission is necessary to release this information where a patient is being treated for alcohol or drug use.

Medicare & Medicaid Assignment: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized benefits are made on my behalf.

Assignment of Insurance Benefits: In the event that I am entitled to insurance benefits arising out of any policy of insurance insuring me or any party liable to be, I hereby assign said benefits directly to STFP for application to by bill. I agree that the clinic may issue a receipt for such payment that such payment shall, discharge the insurance company of any and all obligations under the policy to the extent of the payment and that I shall be responsible for all charges not covered by this agreement.

Signature: _____ Relationship to Patient: _____ Date: _____