OFFICE PROCEDURES

APPOINTMENT REMINDERS: Your doctor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this consent is made by phone and you are not available, a message will be left on your answering machine or with the person answering the phone. By signing this form, you are giving us authorization to contact you with these reminders and information and to leave a message on your answering machine or with individual at your home or place of employment._____

AUTHORIZATION FOR PAYMENT: Your doctor and members of the practice staff may need to disclose your name, address, phone number, billing information and your clinical records to your Insurance Company, Lawyers, Third Party Insurance Company or the credit bureau. This disclosure will be made if we need their assistance ro receive reimbursement for your services, or we need their assistance because the party responsible for reimbursing your service has improperly processed your claim. By signing this form you are giving us authorization to send them this information. You are also giving them authorization to re-disclose your information to the party responsible for the payment of your services, the association's legal counsel, and state or federal agencies that may be asked to intercede on your behalf. _____

THANK YOU CARDS: If you refer a friend, family member, or colleague in to our office, we would like to send you a thank you card. By signing this form you are giving us authorization to send you a card in the mail._____

REFERRAL BOARD: If you refer a friend, family member, or colleague in to our office we would like to put your name on our referral board thanking you for sending him/her to our office. By signing this form you are giving us authorization to display your name on the board._____

FINANCIAL ARRANGEMENTS: We have an open front desk and all our financial arrangements are discussed at the front counter. If you feel you need a more private place to discuss your financial arrangement we can move to the back office. Please notify the office staff or doctor if arrangements need to be made. _____

YOUR RIGHT TO LIMIT USES OR DISCLOSURES: You have the right to request that we may not disclose your health information or specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing, We are not required to agree to your restrictions. However, if we agree with your restriction, the restriction is binding on us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I received a copy of this authorization.

PATIENT NAME PRINTED _____

PATIENT SIGNATURE _____ DATE_____