PATIENT RESPONSIBILITIES

I have received a copy of the Office Financial Policy and understand it is my responsibility to verify with my insurance company if any and all services are covered and/or require preauthorization. I understand that if I have a co-pay, it is payable at the time of service. I hereby authorize my insurance carrier to issue payment directly to Healthworks for all covered services that my dependents or I receive. If I do not have insurance coverage for my dependents or myself, I understand that payment is due at the time of service. I understand that if inaccurate insurance information is given to Healthworks and the information is not corrected until after my insurance company's timely filing limit, I will be responsible for the bill.

______________________________________ ______________________

Patient Signature or Representative Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE REGARDING PROTECTED HEALTH INFORMATION

I have received the Practice's Notice of Privacy.
Photocopies of this document are to be as valid as the original.

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Patient

______________________________________ ______________________

Signature Date

COMMUNICATION PREFERENCES REGARDING PHI

To assist in your care, there may be a necessity to release your ***Protected Health Information*** to someone other than yourself. Please list all individuals authorized for us to discuss your health information.

Yes No

___ ___ Spouse ________________________________ PRINT NAME
___ ___ Parent ________________________________ PRINT NAME
___ ___ Step-Parent ____________________________ PRINT NAME
___ ___ Other Person(s) __________________________ PRINT NAME
___ ___ Caregiver ______________________________ PRINT NAME

May we leave a message on:
Yes No
___ ___ Your answering machine/voice mail at home
___ ___ Your voice mail at work

______________________________________ ______________________

Patient Signature or Representative Date

______________________________________ ______________________

Print Name Account # (Office use only)