Date _____

Patient Name _____ DOB _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE AND CONSENT TO USE AND DISCLOSE HEALTH INFORMATION (Privacy Policy)

Read before signing the Acknowledgement and Consent

This acknowledgement of notice and consent authorizes Eyvazzadeh & Reilly Colon and Rectal Center to use and disclose health information about you for treatment, payment, and health care operation purposes.

Notice of Privacy Practices: Eyvazzadeh & Reilly Colon and Rectal Center has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgement and consent.

Amendments: We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

Mail: Eyvazzadeh & Reilly Colon and Rectal Center
Attention: Privacy Officer
406 Delaware Avenue • Bethlehem, PA 18015
Telephone: (610) 866-2600
Facsimile: (610) 861-7640

ACKNOWLEDGEMENT AND CONSENT (Release of Patient Information)

PRINT or **TYPE** all information except signature.

I have received the Notice of Privacy Practices for Eyvazzadeh & Reilly Colon and Rectal Center. Eyvazzadeh & Reilly Colon and Rectal Center is authorized to use and disclose health information about:

(Patient Name)_____ for treatment, payment, and health care operation purposes consistent with its Notice of Privacy Practices.

(X) _____ _____

(Signature of Patient or Patient's Personal Representative) Date

Personal Representative Information (If Applicable)

_____ _____

(**Print** Name of Patient's Personal Representative) Relationship to Patient (or other authority)

Please complete & sign both sides.

INSURANCE SIGNATURE ON FILE/AUTHORIZATION FORM

(Benefit Assignment)

"I understand that as a courtesy, Eyvazzadeh & Reilly Colon and Rectal Center has agreed to file medical claims for services rendered with my insurance company."

"I request that payment of authorized Medicare/Medigap/Insurance Benefits be made on my behalf to the name of provider of service and (or) supplier for any services furnished to me by that provider of service and (or) supplier. I authorize any holder of medical information about me to release to Centers for Medicare and Medicaid Services and its agents/my Medigap insurer/my insurance company any information needed to determine these benefits or the benefits payable for related services."

"I understand that I am financially responsible for any allowable amounts deemed "my responsibility" by my insurance company such as copays, coinsurance and/or deductibles."

"I understand that, in the event I have no insurance, I am financially responsible for payment of services by Eyvazzadeh & Reilly Colon and Rectal Center at the time of service. If payment in full is not a possibility, a payment plan is established at that time."

"I understand that any collection costs and/or fees for delinquent accounts will be the responsibility of the Patient/Guarantor/Responsible Party."

"I understand that, effective June 1, 2014, a 24 hour notice is required when canceling/rescheduling an Office Appointment to avoid a $10.00 missed appointment fee."

"I understand that, effective June 1, 2014, a 72 hour notice is required when canceling/rescheduling an Outpatient Procedure to avoid a $25.00 missed appointment fee."

"I authorize electronic claim submission of my charges to the appropriate insurance carrier."

"I authorize my medical record reports to any facility deemed necessary in the care of my treatment."

"I have read, fully understand and agree to abide by the policies listed above."

(X) _____

(Patient/Legal Guardian/Responsible Party Signature) Date

PATIENT COMMUNICATION FORM

I authorize EYVAZZADEH & REILLY COLON AND RECTAL CENTER and/or their staff to communicate medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes.

Leave Appointment Message on:
- ❑ Answering Machine
- ❑ Office Voice Mail
- ❑ w/ Another Person
- ❑ Through Mail
- ❑ Via E-mail _____

Leave other Medical Information on:
- ❑ Answering Machine
- ❑ Office Voice Mail
- ❑ w/ Another Person
- ❑ Through Mail
- ❑ Via E-mail _____

List person(s) we are authorized to communicate with in regard to your medical information.

_____ _____

_____ _____

How often do you have someone (like a family member, friend or hospital worker) help you read hospital material?
❑ Never ❑ Sometimes ❑ Always

How confident are you filling out medical forms by yourself? ❑ Never ❑ Sometimes ❑ Always

How often do you have problems learning about your medical condition because of difficulty understanding written information? ❑ Never ❑ Sometimes ❑ Always

Race: *(please check all that apply)* ❑ Caucasian ❑ Hispanic ❑ African American ❑ Asian ❑ Other _____

Ethnicity: ❑ Hispanic/Latino ❑ Non-Hispanic/Latino ❑ Other _____

(X) _____

(Patient Signature)