PATIENT ACKNOWLEDGEMENT AND RECEIPT OF PRIVACY PRACTICES

PRACTICE NAME: Treasure Coast Obstetrics & Gynecology, P.L.
1000 37TH Place, Suite 105
Vero Beach, FL 32960

I. My signature below acknowledges that I _____ have received, read and understand the Treasure Coast Obstetrics &. Gynecology's Privacy Notice.

II. I, _____ understand that based on my condition and treatment, I am authorizing Treasure Coast Obstetrics & Gynecology to bill my parent's and/or legal guardian's insurance company for all services rendered to me.

III. I, _____ understand that in giving my consent above to bill the insurance company for my services, that I am releasing private, confidential medical information to the insurance carrier (from the insurance card I presented) and to the insured and/or parent/guardian.

IV. I, _____ DO NOT want to release any confidential information of my medical condition, services rendered and diagnosis to the insurance company, the insured, or to my parents or guardian. Therefore, I will be financially responsible for payment of my services at the time of service.

V. I, _____ give / do not give (circle one option) my permission to _____ to receive all medical information regarding my care while I am a patient of Treasure Coast Obstetrics & Gynecology.

The date signed below is the effective date of this agreement and can be revoked, changed or altered at any time with written consent from me to Treasure Coast Obstetrics & Gynecology, P.L.

SIGNATURE OF PATIENT: _____

PRINTED NAME OF PATIENT: _____

DATE OF BIRTH: _____

DATE SIGNED: _____