PATEL HEALTHCARE LLC

Patient's Name:_____Patient's Birth Date:_____SSN: _____

Authorization to Pay:

- I request that payment of claims for authorized benefits be made either to me or, if the payer accepts assignment, I authorize payment direct to the physician or to this office for any services furnished to me by the physician. I authorize any holder of medical information about me, to release it to the Health Care Financing Administration and its agents or to my insurer or to third party payers as needed to determine the benefits payable for related services and for claim adjudication.

- I understand I am ultimately responsible for any services provided to me.

Acknowledgement of Receipt of Notice of Privacy Practices:

I acknowledge that I received a copy of Provider's Notice of Privacy Practices:

- It tells me how office/practice will use my health information for the purposes of my treatment, payment for my treatment and practice's healthcare operations.
- The notice explains in more detail how office/practice may use and share my health information for other than treatment, payment and health care operations.
- Office/practice will also use and share my health information as required/permitted by law.

Consent to obtain health and prescription history:

I hereby permit office/practice to obtain and exchange prescription history and information from/with external sources, including electronic pharmacy and insurance exchanges

Consent for electronic/telephonic communication:

- I understand that electronic communication should NOT be used in the case of a need for emergency care.
- I hereby request electronic communication via email that contains a link to protected health information in my health record maintained or created by or for the office/practice.
- I understand that by providing an email address, I attest that I control access to its information.

- I understand that by providing an Email address and creating a secure Email account, I am agreeing not to share my password with others where unwanted access may occur.
- I understand that office/practice will not solicit either my email address password or my secure email account password. These passwords are my sole responsibility for up keep.
- I understand that I may revoke this consent at any time by providing the office/practice with verification of my identity and requesting that my current email address be removed from the system. I understand that communications that have been sent prior to revocation cannot be retracted.
- I understand that telephonic or text messages can also be sent to phone numbers that I have provided to the office.
- I understand that this electronic communication is offered solely on the discretion of office/practice and may be withdrawn to any patient at any time.

I agree to the statements above and wish to have electronic communication sent to me by office/practice.

_____ _____

Signature of Patient/Patient's Legal Representative Date:

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Relation to the patient