John B. Hirt D.O.

Consent Form

AUTHORIZATION

I, the undersigned, certify that I (or my dependent) has insurance coverage as listed above and assign directly to John B. Hirt D.O. understand that I am Financially responsible for all charges whether or not paid by insurance within 30 days. I hereby authorize John B. Hirt D.O. to release all information necessary to secure payment of benefits. I authorize the use of this signature for all insurance claims.

X Signature_____ Date _____

Are you the Guarantor? Yes ____ No ____ If not please see receptionist.

Consent for Treatment

Having voluntarily presented myself (or my dependent) John B. Hirt D.O. I acknowledge recognition of the fact that the evaluation and treatment received, I also give John B. Hirt D. O. permission to discuss RX history, advised or deemed necessary, to be the judgment of the Physician.

X Signature _____ Date _____

Acknowledgement of Receipt of Privacy Notice (HIPPA)

By signing this form, you acknowledge that John B. Hirt has offered or given to you a copy of the Privacy Notice, which explains how your health information will be handled in a various situation. We must attempt to have you signed this form on your first date of service with us after April 14, 2003. This includes the situation where your first date of service occurred electronically. If your first date of service with us was due to an emergency, we must attempt to give you this notice and get your signature acknowledging receipt of this notice as soon as possible after the emergency.

- I have received a copy of the Privacy Notice of John B. Hirt D.O.
- John B. Hirt D. O. has offered me a copy of the Privacy Notice which I have declined and has given me the chance to discuss my concerns and question about the privacy of my health information

X Signature _____ Date_____

Additional Person(s) Authorized to Make the Use or Disclosure of my PHI

The staff of John B. Hirt value and do everything in our power to protect your privacy. Your medical information will not be given to any individual (Including spouses, parents, children, or any significant others without your written consent). If you want anyone other than your referring physician to have access to your medical information please list their name, address, relation, and phone number below. (Note: Uses and disclosures may be permitted without prior consent in an emergency).

Name _____ Relation_____

Name _____ Relation_____

Name _____ Relation_____

X Signature _____ Date_____

The staff of John B. Hirt should complete this section if Acknowledgement Form is not signed by the Patient:

1. Does the patient have a copy of the Privacy Notice? Yes ___ No __
2. Please explain why the patient was unable to sign an acknowledgement _____

Employee Signature:_____ Date_____