

Elizabeth B.W. Anderson, MD, PLLC

AUTHORIZATION TO REVEAL MEDICAL AND BILLING INFORMATION

I authorize Elizabeth B.W. Anderson, MD, PLLC and staff to reveal to the following individuals, as needed, information regarding my protected health information and billing information. I understand that once this information is disclosed to these individuals, Elizabeth B.W. Anderson, MD, PLLC will not have responsibility over to whom these individuals reveal this information. I may revoke this authorization by giving written notice to Elizabeth B.W. Anderson, MD, PLLC.

1. Name: _____ Relationship: _____

2. Name: _____ Relationship: _____

3. Name: _____ Relationship: _____

Signed: _____ **Date:** _____
(patient or guardian)

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I hereby acknowledge that I have read and understand the Privacy Practice notice provided to me by Elizabeth B.W. Anderson, MD, PLLC. I understand that this notice will be in effect until further notice from Elizabeth B.W. Anderson, MD, PLLC.

Signed: _____ **Date:** _____
(patient or guardian)

AGREEMENT TO PAY

In order to establish an optimal relationship and avoid misunderstandings and confusion regarding our payment policies, our staff is trained to inform you of the financial payment policies of this office. Payment is required at the time services are rendered unless you are covered by an insurance company with which Elizabeth B.W. Anderson, MD, PLLC participates.

I understand that my insurance will be attempted to be verified and I will be asked to pay for all services not covered, deductible amounts, and co-pays that Elizabeth B.W. Anderson, MD, PLLC does participate with that are due at the time of service. We accept payment in the form of cash, check, or credit card. For patients with HMO coverage or other third party that require authorizations, I will be held responsible for payment if this referral authorization is not provided at the time of service. I, as the patient or responsible party for the patient, agree to be responsible for charges or services referred to another physician or laboratory by any physician/practitioner of Elizabeth B.W. Anderson, MD, PLLC.

I understand that failure to make payment when due is the basis for legal action, and agree to pay any and all cost of collection, including attorneys' fees.

I authorize and request that payment by an authorized insurance company be made payable to Elizabeth B.W. Anderson, MD, PLLC on my behalf for the services furnished to me by the physician(s)/practitioner(s) of Elizabeth B.W. Anderson, MD, PLLC.

This signature verifies the agreement to the above as the patient or the responsible party for the patient.

Signed: _____ **Date:** _____
(patient or guardian)