



Consents, Releases, and Agreements

Patient Name (please print) _____

Date of Birth _____

Notice of Uses and Disclosures of Protected Health Information:

I acknowledge that I have been provided with Restoration Osteopathic Medicine's (ROM) Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that may occur in my treatment, payment of bills, or in the performance of health care operations of ROM, as well as my individual rights and the duties of ROM with respect to my protected health information. I understand that Restoration Osteopathic Medicine may use or disclose my protected health information (PHI) to diagnose or provide treatment for me, to obtain payment for health care expenses, or to conduct health care operations. PHI includes information created, maintained, or received by ROM that identifies me, or from which my identity could be determined, and which relates to my past, present or future physical or mental health, condition, treatment, or payments for medical services. ROM reserves the right to change the privacy practices that are described in its Notice of Privacy Practices. ROM will post any revised Notice of Privacy Practices in its office. In addition, I may obtain a revised Notice of Privacy Practices by contacting ROM and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Office Policies (Please see posted policies; a copy can be made for your records):

- No Show and Cancellation Policy
- No Smoking Policy
- HIPAA Compliance

Patient Signature _____

Date _____

Financial Agreement and Assignment of Benefits:

Medicare: I request that payment under the medical insurance program be made either to me or to Restoration Osteopathic Medicine (ROM) on any bills for services furnished to me during the effective period of this authorization and I authorize the above named provider to release to the Social Security Administration or its intermediaries or carriers any information needed for this claim or any related Medicare claim.

All other Payors: I authorize payment directly to ROM of all benefits otherwise payable by any insurance policy(s) and I hereby irrevocably assign such benefits to ROM in an amount not to exceed the charges for services rendered. I agree to be financially responsible for the balance left after processing by my insurance. If not covered by insurance, I agree to be financially responsible for services rendered. If I am unable to pay in full, I understand that a payment plan may be established.

Patient Signature _____

Date _____