Privacy Practice Acknowledgement

I have received the **Notice of Privacy Practices** and have been provided an opportunity to review it.

Signature	Print Name	Date

Individual Patient's Authorization

I give my authorization to use or disclose my (PHI) Protected Health Information to my doctors, insurance companies and attorneys (with a signed, written release). This office will permit only trained, authorized employees to have access to my PHI. I understand that this office will not reveal my information to any external organization other than those previously mentioned. This office has assured me that my information will be safeguarded according to strict standards of security and confidentiality any information shared with them. I give my permission to be called to reschedule appointments, to be sent postcards and be sent newsletters for health information purposes.

DISCLAIMER

I understand that I may be financially responsible for any charges incurred at this office, including copays, deductibles and charges denied or not covered by my insurance company.

I realize my care may be subject to pre-authorization by the insurance company, and I accept any responsibility for charges that may not be approved. The insurance company will review any and all documentation submitted by Dr. Bruce N. handelsman for review for medical necessity and base their approval/denial on this documentation.

I understand that this office agrees to notify me as soon as possible if a service is not covered and will notify me if my care is not approved by the insurance company. If a treatment plan is approved, this office will make me aware of the number of office visits allowed and the timeframe of the authorization. Initial visits may be denied and this may be beyond the office's ability to notify the patient prior to rendering acute care, while waiting for insurance coverage approval. These charges will be the patient's responsibility if denied by the insurance carrier.

This office may seek payment from you for any services your health insurance plan determines to be not medically necessary.

I have read and understand my obligations for payment for care in the absence of insurance coverage.

Signature	Print Name	Date