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Patient Printed Name: _____ **DOB** _____

CONSENT TO TREAT

_____(initial) I request and authorize outpatient care as my physician, his/her assistant or designee may deem necessary or advisable.

INSURANCE

_____(initial) I understand that it is my responsibility to know my insurance and the rules of payment. If my insurance does not pay for services, I understand it is my sole responsibility and I will obtain any referrals required.

PRIVACY PRACTICE ACKNOWLEDGEMENT

_____(initial) The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights and the practices legal duties with respect to my information. I understand I can obtain this practice's current Notice of Privacy Practices upon request.

I give Lung and Sleep Center permission to discuss my medical records with the following persons:

Name: _____ Phone: _____ Relation: _____

Name: _____ Phone: _____ Relation: _____

Name: _____ Phone: _____ Relation: _____

Signature: _____ **Date:** _____