MD Progressive Care

Authorization To Release Information:
I hereby authorize MD Progressive Care to release to my insurance carrier(s)
Billing any information acquired in the course of my examination or treatment required for payment of any insurance claim.

Signed:_____Dated:_____

Assigment of Benefits:
I hereby authorize payment directly to MD Progressive Care for medical benefits. I understand that I am *financially responsible for the charges not covered by the insurance company.*

Signed:_____Dated:_____

Electronic Privacy Waiver:
I understand that my medical records may be transmitted electronically. Although every effort will be made to assure the records are sent/received by the appropriate third party, I absolve MD Progressive Care from liability should they be received in error by a third party. I give my consent to fax my records *for the purposes of treatment, payment, or healthcare operations and understand that I may withdraw this consent at any time in writing.*

Signed:_____ Dated:_____

Acknowledgement of Office Policies:
I am aware that I will be charged $35 for same day cancellation $50 for missed appointments not cancelled 24 hours in advance. I am also *aware that $25 will be charged for preparation of FMLA/private disability forms at the time the forms are dropped off at the office.*

Signed:_____ Dated:_____

Permission to Share Medical Information:
You have my authorization to share my medical records and medical information with the following people:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Signed:_____ Dated:_____

If you would like them released to no one then sign here:_____

Permission to Leave Messages on Answering Machine:
By signing below you authorize us to leave messages regarding appointment reminders, referral information, etc. on the numbers below. We will use your email address to create a portal account for you so you can access your labs/appointment reminders/messages though our secure portal:

Email Address: _____

Mobile Number (_____)_____-_____ Other Number (_____)_____-_____

Signed:_____ Dated:_____

By signing below you additionally authorize your physician to leave messages regarding abnormal lab values/other clinical information on the above numbers.

Signed:_____ Dated:_____

MD Progressive Care Patient Consent Form

Consent to the Use and Disclosure of Health Information
for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- *a basis for planning my care and treatment*
- *a means of communication among the many health professionals who contribute to my care*
- *a source of information for applying my diagnosis and surgical information to my bill*
- *a means by which a third-party payer can verify that services billed were actually provided*
- *and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals*

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

___Accepted _____ Denied

_____
(Signature of Patient or Legal Representative)

_____
(Printed Name of Patient or Legal Representative)

_____
(Date Notice Effective)