HIPAA CONSENTS AND FINANCIAL POLICIES FOR JOHN A AZZATO MD PC

PATIENT____

(Last) (First) (MI)

Patient Acknowledgement of Receipt of Notice of Private Practices: I acknowledge that I have received or have been offered a copy of John A Azzato MD PC's Notice of Privacy Practices, which provides information about how John A Azzato MD PC uses and discloses protected health information (PHI) about me.

Consent To Disclosure of PHI to Family Members, Relatives, Friends or Others: I agree that John A Azzato MD PC may disclose my PHI to the following family members, relatives, friends or others. I understand that, if I am present John A Azzato MD PC may discloser my PHI to other family members, relatives or friends if I orally agree or do not object. I also understand that, if I am not present or am incapacitated, John A Azzato MD PC may make limited disclosure of my PHI to other family members, relatives or friends if John A Azzato MD PC determines in its professional judgment that such disclosure is in my best interest.

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Name Relationship Phone Number

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Name Relationship Phone Number

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Name Relationship Phone Number

Consent for Treatment: I hereby authorize the performance of any medical or surgical treatment which may be advised and recommended by my physician at John A Azzato MD PC. I further consent that John A Azzato MD PC may obtain and use information from other healthcare providers such as pharmacies and hospitals.

Financial Agreement: I understand that I am financially responsible to my physician at John A Azzato MD PC for services rendered and charges not covered by insurance. I understand that My insurance will be filed as a courtesy to me and allow payment of any filing to be made to John A Azzato MD PC. **If I have no insurance to cover services rendered, a predetermined amount will be provided prior to services being rendered.** I understand John A Azzato MD PC does not accept third party liability such as in legal cases, & I am ultimately responsible for payment.

I certify that the information provided is correct to the best of my knowledge. I will not hold my Doctor or any members of his staff responsible for any errors or omissions that I may have made in completion of this form.

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Signature of Patient or Legal Guardian Date Rev. 3/13