Assignment and Release

I, _____, the undersigned, certify that I (or my dependents) have insurance coverage with (*name your insurance carrier*) _____ and or the insurance Simon Family Medicine has on my file, and I assign directly to *Dr. Simon* all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize *Simon Family Medicine* to bill my insurance company and to release all information necessary to secure the payment of benefits. I also authorize the use of this signature on all insurance submissions. I understand that my "Private Healthcare Information" will be used according to the Office Policy and Regulations. **I understand that I am ultimately responsible for the charges incurred in this office, regardless of the type of insurance that I have**. I am also aware of the 1.5% finance charges that may be assessed on my account if over 30 days past due.

_____ _____

Patient/Guarantor Signature Today's Date

SIMON Family Medicine
YOUR FAMILY'S DOCTOR

Acknowledgement of Receipt of Notice of Privacy Practices

The Health Insurance Portability and Accountability Act (HIPAA) requires us to give you a notice of our privacy practices and to acknowledge your receipt of the notice.

The Notice of Privacy Practices explains how your protected health information may be used or disclosed by us. In addition, it explains your rights with regard to your protected health information, as well as our legal responsibilities.

(1) It is important for us to honor the confidentiality between patient and Simon Family Medicine. **Please check your preference(s) below:**

- You may discuss my medical information **ONLY** with me ☐ Yes ☐ No
- You may discuss my medical information with the following people:

Name	Relationship	Phone#

☐ You may leave medical information (test results, prescription refill information, etc.) on my voice mail at:

Cell #: _____ Home #: _____

☐ Do NOT leave medical information on any voice mail.

(2) I do hereby acknowledge that Simon Family Medicine has provided me with a notice of its privacy practices, as required by Federal law (HIPAA) and consent to share my medical information with the above listed.

Print Name of Patient	Patient DOB	Signature of Patient	Today's Date

Note: If the individual listed above is a minor child or legally incapacitated, a parent or legal guardian/representative should sign below on behalf of the individual and list their relationship.

Signature of Parent/ Legal Guardian/Representative	Date	Relationship