Dpinder Singh, MD

Financial Policy, Assignment Information, and Release of Information

I authorize release of any information acquired in the course of treatment necessary to complete and file medical claims to my insurance company or Medicare on my behalf. I hereby acknowledge financial responsibility for costs of services rendered for me or for the person whose account I am acting as guarantor. I authorize (assign) any insurance or Medicare benefits to be paid directly to Dpinder singh, MD or its assignees. I am responsible for any non-covered services, supplies, co-payments or deductibles. I am responsible for knowing how my plan works, and I request medical services at this office. This acceptance and assignment will be in force for all future services by practitioners from this office.

_____ _____

Signature of Patient or Patient's guardian/representative Date

_____

Printed name of person signing above

Acknowledgement of Notice of Privacy Practices

I understand that as part of my health care, Dpinder Singh,MD originates and maintains paper and/or electronic 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.

I understand that Dpinder Singh,MD maintains a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. The most recent version of this Notice is displayed in the waiting room area. I understand that West Cary Family Physicians reserves the right to change this notice and its practices as needed and will make a reasonable attempt to inform me of any changes. I understand that I can request an additional written copy of this Notice at any time. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent, and
- The right to request restrictions as to how my health information may be used or disclosed.

I have had an opportunity to receive and review the *Notice of Privacy Practices* of West Cary Family Physicians.

_____ _____

Signature of Patient or Patient's guardian/representative Date

_____

Printed name of person signing above

OTHER INFORMATION		
Pharmacy name:	Pharmacy location:	Pharmacy phone no: ( ) -
How did you hear about this clinic, or who referred you here?		