CRYSTAL LAKE HEALTH CENTER

www.crystallakeclinic.com

NOTICE OF PRIVACY PRACTICES

I acknowledge receipt of a copy of Crystal Lake Clinic's Privacy Practices.

AUTHORIZATION FOR MEDICAL TREATMENT, RELEASE OF MEDICAL INFORMATION, AND ASSIGNMENT OF BENEFITS

I hereby authorize treatment of myself (or my minor child) for the purposes of receiving medical care at Crystal Lake Clinic, P.C.

I authorize Crystal Lake Clinic, P.C. to release any medical information necessary to process my insurance claim(s).

I authorize and request payment of medical benefits directly to Crystal Lake Clinic, P.C.

I agree that this authorization will cover all medical services rendered until such authorization is revoked by me in writing.

I agree that a photocopy of this form may be used in lieu of the original.

I understand that I am financially responsible for all charges incurred and I am responsible to obtain all second opinions or referrals.

FINANCIAL POLICY

I have received a copy of Crystal Lake Clinic's Financial Policy and understand that it is my responsibility to read it and ask questions if necessary.

Print - Patient or Child's Name _____ Date of Birth _____

Print - Parent /Guardian Name _____

X _____ _____ _____

Signature of Patient/Parent/Guardian | Date | Relationship to Patient

Rev 10/9/2017kb