

One Family Doctor / John Watts Haresch, MD

Patient Consent for Medical Care and Assignment of Benefits Patient Consent for Use and Disclosure of Protected Health Information Written Acknowledgement of Receipt of Notice of Privacy Practices

I authorize **John Watts Haresch, MD** to provide me medical services.

Payment Assignment.

I authorize my insurance benefits be paid directly to **John Watts Haresch, MD** or One Family Doctor. I agree to pay any required co-payments at the time of service. I also understand that I am responsible for services not paid by insurance.

Communication.

John Watts Haresch, MD may *call* my home or other alternative location and *leave a message* on voice mail or in person for items of treatment, payment, and healthcare operations, such as appointment reminders, insurance items, and clinical care, including test results.

John Watts Haresch, MD may *mail* to my home or other alternative location items for treatment, payment, and healthcare operations, such as appointment reminder cards, financial statements, and clinical care items, including test results. Clinical information will be marked Personal and Confidential.

John Watts Haresch, MD may *e-mail* to me items in reference to treatment, payment, and healthcare operations, such as appointment reminders and announcements. Clinical information will only be offered through a secure and confidential system.

Privacy Practices.

I acknowledge receiving the Notice of Privacy Practices. I have the right to review this Notice prior to signing this consent and to obtain a copy at any time. This Notice can be revised at any time.

As outlined in the Notice of Privacy Practices, I authorize **John Watts Haresch, MD** to use and release my protected health information for treatment, payments, and healthcare operations.

I have the right to request that **John Watts Haresch, MD** restrict the use or disclosure of my protected health information. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **John Watts Haresch, MD** may decline to provide treatment to me.

I specifically authorize **John Watts Haresch, MD** to communicate issues of my health and medical care with the following persons (Please list contact information):

Signature of Patient or Legal Guardian

Date

Print Patient's Name

Patient's Date of Birth

Print Name of Legal Guardian

Relationship to Patient