ACKNOWLEDGMENT OF RECEIPT OF TOLEDO CLINIC'S NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I acknowledge that I have received Toledo Clinic's Notice of Privacy Practices effective April 14, 2003.

Staff Use Only

PATIENT CHART NUMBER _____

_____
Signature of Patient

_____
Printed Name of Patient

_____
Date of Birth

_____
Signature of Parent/Guardian of Minor

_____
Date

Staff use Only

Good Faith Effort to Obtain Acknowledgment

The above named patient refused to sign the acknowledgment after being requested to do so.

_____
Staff Member Signature

Date: _____

PERSONS THAT ARE ALLOWED TO GIVE/RECEIVE MY PRIVATE HEALTH INFORMATION

METHOD OF ALLOWED RELEASE: _____VERBAL _____WRITTEN

| Name | Relationship | Phone # |
|---|---|---|
| Name | Relationship | Phone # |
| Name | Relationship | Phone # |

TOLEDO CLINIC
4235 Secor Road
Toledo, Ohio 43623

## Billing Policy

All outpatient visits should be paid on the day of the visit. I understand that I am responsible for full payment of all charges for medical services rendered by Toledo Clinic, Inc. physician(s) regardless of insurance coverage, unless a contractual agreement exists with my insurance carrier and my physician.

## Signature on File

I hereby authorize the Toledo Clinic, Inc. to submit to my insurance plan all covered services rendered by the physician(s) and to furnish complete information (including Medical Records, if necessary) to my plan regarding services rendered. I understand that in signing this form, the Clinic will not release to anyone, including those processing my Clinic claim, any information that the law specifically protects and for which a special consent is required. For those records to be released, I will need to sign a separate consent. I authorize and direct my insurance carrier to issue payment check(s) directly to the physician(s) rendering covered services unless otherwise notified.

## Authorization Signature

I have read this form or had it read to me. I understand it.

_____ _____

**Signature of Patient/Authorized Representative** **Relationship (if other than patient)**

| Patient Name |
| --- |
| Chart # |

**Date:**_____