BITRAN & RIVERA, MD, LLC

AUTHORIZATION

I, the undersigned certify that I (or my dependent) has insurance coverage as listed above and assign directly to Bitran & Rivera, MD, LLC I understand that I am financially responsible for all charges whether or not paid by insurance. I remain responsible for payment of co-pays, deductibles, non-covered services, and any other charges not paid by insurance within 30 days. I hereby authorize Bitran & Rivera, MD, LLC to release all information necessary to secure payment of benefits. I authorize the use of this signature for all insurance claims.

X Signature____**Date**__________________

Are you the Guarantor? Yes__ No __ If not please see receptionist.

CONSENT FOR TREATMENT

Having voluntarily presented myself (or my dependent) to Bitran & Rivera, MD, LLC I acknowledge recognition of the fact that the evaluation and treatment received from Bitran & Rivera, MD, LLC is advised and deemed necessary to be the judgment of the Physician.

X Signature____**Date**__________________

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE (HIPPA)

By signing this form, you acknowledge that Bitran & Rivera, MD, LLC has offered or given to you a copy of its Privacy Notice, which explains how your health information will be handled. We must attempt to have you sign this form on your first date of service with us after April 14, 2003. This includes the situation where your first date of service occurred electronically. If your first date of service with us was due to an emergency, we must attempt to give you this notice and get your signature acknowledging receipt of this notice as soon as possible after the emergency.

☐ **I have received or read a copy of the Privacy Notice of Bitran & Rivera, MD, LLC.**

☐ **Bitran & Rivera, MD, LLC has offered me a copy of the Privacy Notice which I have declined and has given me the chance to discuss my concerns and questions about the privacy of my health information.**

X Signature____**Date**__________________

CONSENT FOR DISCLOSURE OF PERSONAL MEDICAL INFORMATION

As a patient I agreed to let certain individuals participate in discussions and decisions related to my medical care. Therefore, I hereby authorize the physicians and staff of Bitran & Rivera, MD, LLC to disclose my personal medical information to the following individual(s).

___ Bitran & Rivera, MD, LLC may disclose my medical information only in my presence.

___ Bitran & Rivera, MD, LLC may disclose my medical information when I am not present, this includes telephone calls, fax or mail.

__I understand that this consent may be revoked by me at anytime by written notice of Bitran & Rivera, MD, LLC.

Name ______________________________ Relation __________________ Phone ________________
Name ______________________________ Relation __________________ Phone ________________
Name ______________________________ Relation __________________ Phone ________________

__ Person(s) listed above age 18 or older may pick up prescription when I am not present.

X Signature____**Date**__________________

Witness Signature____________________________________ **Date** __________________

The staff of Bitran & Rivera, MD, LLC should complete this section if Acknowledgement Form is not signed by the Patient:

1. Does the patient have a copy of the Privacy Notice? Yes__ No __
2. Please explain why the patient was unable to sign an acknowledgement form and our efforts in trying to obtain the patient signature: ____

Employee Signature: ____________________________________ Date ______________________