PATIENTS NAME: _____

CHART#: _____
DATE: _____

CAMPBELL CUNNINGHAM
LASER CENTER

The Patient or Guarantor is responsible for payment in full of all services rendered by physicians or employees of Drs. Campbell, Cunningham, Taylor & Haun. Payment in full is expected at the time of service unless arrangements are made in advance.

AUTHORIZATION, ASSIGNMENT, AND RESPONSIBILITY OF ACCOUNT

I hereby authorize Drs. Campbell, Cunningham, Taylor & Haun to release to the insurance companies and/or their intermediaries and/or carriers any medical or other information needed for claims reimbursement.
I hereby assign, transfer, and set over to Drs. Campbell, Cunningham, Taylor & Haun all medical reimbursement benefits under my insurance policy with documented insurance companies.
I hereby acknowledge and accept responsibility for payment in full of all non-covered services rendered to me by Drs. Campbell, Cunningham, Taylor & Haun. Should it be necessary to enforce the provisions of this agreement through an attorney or any legal proceedings, the undersigned promises to pay all costs of collection, including reasonable attorney's fee and all court costs.

ASSIGNMENT OF MEDICARE BENEFITS

I request that payment of authorized Medicare benefits be made on my behalf to Drs. Campbell, Cunningham, Taylor & Haun for any service furnished to me by a physician of the group. I authorized any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare carrier and **I am responsible for the Medicare deductible, co-insurance or the 20% Medicare does not pay, and for any non-covered services.**

MEDIGAP OR OTHER SECONDARY INSURANCE

I request that the payment of authorized Medigap benefits be made either by me or on my behalf to Drs. Campbell, Cunningham, Taylor & Haun, or any physician of that group, for services provided to me by a physician of the group. I authorize any holder of medical information about me to release it to my Medigap insurer or any information needed to determine these benefits payable for related services. This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

_____ _____
Date Signature of Patient / Guardian

HIPAA Privacy Rule gives you the patient the right to request on uses and discloses of your Protected Health Information (PHI). You also have the right to request confidential communications or that of PHI be made by alternative means, such as sending correspondence to an alternate address or call a different phone number than what is listed. Drs. Campbell, Cunningham, Taylor & Haun has my authorization to contact me in the following manner:

Home Telephone #: _____
☐ O.K. to leave message with detailed information
☐ Leave message with call back number only
☐ Please only leave a message with _____ _____
Contact Person's Name Relationship

Work Telephone #: _____
☐ O.K. to leave message with detailed information
☐ Leave message with call back number only
☐ Other _____

Written Communications
☐ O.K. to mail to my home address
☐ O.K. to fax to this number _____

Patient Initials: _____ Date: _____

I hereby acknowledge reading the Notice of Privacy Practices and understand that I have the right to obtain a paper copy of this notice.

_____ _____
Date Signature of Patient / Guardian