PRIVACY NOTICE

IN COMPLIANCE WITH HIPPAA REGULATIONS, I HAVE RECEIVED A COPY OF *SCPS* NOTICE OF PRIVACY PRACTICES. THE NOTICE OF PRIVACY PRACTICES EXPLAINS FEDERAL LAW STANDARDS AND MY PRIVACY RIGHTS AS A PATIENT. WE KEEP A RECORD OF THE HEALTH CARE SERVICES WE PROVIDE YOU. YOU MAY ASK TO SEE AND COPY THAT RECORD AT ANY TIME. YOU MAY ALSO ASK TO CORRECT THAT RECORD.

CONSENT FOR TREATMENT

BY MY SIGNATURE BELOW, I HEREBY CONSENT TO AND AUTHORIZE THE ADMINISTRATION OF ROUTINE TESTS, TREATMENTS, INJECTIONS, ANESTHETICS, AND/OR MINOR IN-OFFICE SURGICAL PROCEDURES DEEMED NECESSARY AND PERFORMED BY SURGEONS FOR THE PROPER TREATMENT OF THE PATIENT NAMED ON THIS FORM FOR ONE YEAR FOLLOWING THE DATE OF THE SIGNATURE LISTED BELOW.

CONSENT TO RELEASE INFORMATION

BY MY SIGNATURE BELOW, I AUTHORIZE *SCPS* TO MAKE AVAILABLE TO PHYSICIANS, HOSPITALS AND CLINICS, COPIES OF PERTINENT PORTIONS OF MY RECORDS HELD BY *SCPS* IF REQUESTED OR REQUIRED, IN THE INTEREST OF MY HEALTH. ANY RELEASE OF MY PROTECTED HEALTH INFORMATION HAS BEEN OUTLINED TO ME IN THE *SCPS* NOTICE OF PRIVACY PRACTICES OF WHICH I HAVE BEEN OFFERED A COPY.

NON-COVERED SERVICES

WE ENCOURAGE YOU TO BECOME FAMILIAR WITH COVERAGE PROVISIONS OF YOUR INSUANCE, INCLUDING PRE-AUTHORIZATION REQUIREMENTS. BY MY SIGNATURE BELOW, I ACCEPT RESPONSIBILITY AND COMMIT TO PAY FOR ALL UNPAID BALANCES GENERATED IN GOOD FAITH ON MY BEHALF [OR ON BEHALF OF THE PATIENT I REPRESENT] BY *SCPS* IN THE EVENT THAT THE SERVICES ARE NOT COVERED, FOR ANY REASON, BY MY INSURANCE COMPANY.

ASSIGNMENT OF INSURANCE BENEFITS

BY MY SIGNATURE BELOW, I HEREBY AUTHORIZE AND ASSIGN DIRECTLY TO *SCPS* ALL MEDICAL/SURGICAL BENEFITS PAYABLE FOR ALLOWABLE EXPENSES OTHERWISE PAYABLE TO ME FOR SERVICED RENDERED. THIS PAYMENT WILL NOT EXCEED MY INDEBTEDNESS TO *SCPS*. I AUTHORIZE THE RELEASE OF INFORMATION REQUIRED BY INSURANCE COMPANIES AND/OR THEIR AGENTS, AND GOVERNMENT AGENCIES AND/OR THEIR INTERMEDIARIES, TO FACILITATE PAYMENT.

_____   _____

SIGNATURE OF PATIENT OR REPRESENTATIVE   DATE