

Purvisha Patel, M.D.

CONSENT FOR CARE

I hereby give my consent for treatment to Purvisha Patel, M.D.

Signature: _____ Date: _____
Patient, Parent or Guardian Relationship

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

I hereby authorization payment to Purvisha Patel, M.D. for services rendered to me or my dependants. I also authorize this office to release any information necessary to expedite insurance claims. I understand that I am responsible for any balance not covered by insurance and/or collection costs and legal fees incurred in an attempt to collect said balance.

Signature: _____ Date: _____
Patient, Parent or Guardian Relationship

LIFETIME AUTHORIZATION TO FILE MEDICARE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Purvisha Patel, M.D. for services furnished me by that provider. I also authorize any holder of medical information about me to release to the Center for Medicare/Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature: _____ Date: _____
Patient, Parent or Guardian Relationship

AUTHORIZATION TO LEAVE MESSAGE

I hereby authorization Purvisha Patel, M.D. to leave a message regarding pending appointments/or tests at my residence. yes no . It is ok to leave a message with my employer yes no. It is ok to leave a message with family member: _____ (list who) phone number _____.

Signature: _____ Date: _____
Patient, Parent or Guardian Relationship

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY

I have received a copy of the Notice of Privacy Practices as required by HIPAA Privacy Regulations, developed October 2005.

Signature: _____ Date: _____
Patient, Parent or Guardian Relationship