

**Authorizations and Acknowledgements**

**HIPPA Acknowledgement:**

I have been presented with a copy of this office’s Notice of Private Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of this notice and I request the following restriction(s) concerning the use of my personal information.

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| --- |
| Signed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  If not signed by patient, indicate relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  If patient refuses to sign, indicate your attempt to obtain a signature  ( ) Patient refuses to sign this acknowledgement Employee Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Assignment of Benefits:**

I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Migraine Relief Center (MRC) insurance company or providers to release or obtain any information required to process my claims, render medical care to me or participate in my care. I the undersigned, am the responsible party for the patient named above, and agree to pay in full or any balance owed after the insurance has paid the claim. Should your insurance company provide you with payment for services rendered through our office, it is your responsibility to either endorse that check or provide payment within 5 business days of receipt of that check. You agree that any failure to due so will allow us to prosecute you to the highest extent of the law in both civil and criminal court.

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Signature of Responsible Party Printed Name Date

**Authorization to Photograph:**

I hereby authorize the physicians and/or staff of MRC to take photographs prior to, during, and or following surgical treatment and use them for the purposes of medical education, treatment planning, documentation, or other purposes not limited to but including publications in journals.

Patient/Responsible Party Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Non Workman’s Compensation Declaration:**

Physicians are unable to determine whether or not the symptoms you are suffering from is work related. It is your responsibility to inform our office if you file a workman’s compensation complaint. By signing below you declare that you do not have a compensable work injury covered under workman’s comp claim at this time. You also understand that should your workman’s comp claim be denied, you will be responsible for all balances due in full. If group health insurance is available, we must receive a copy for processing as soon as you are aware the claim was denied. This is not a guarantee that we accept your group insurance. I declare that this is not a work related injury/ailment.

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Signature of Responsible Party Printed Name Date