Acknowledgement of Privacy Statement, Authorization and Assignments of Benefits

Patients Name (Please print) ____Date of Birth __________________________

Guarantor's Name (Please print) ____Date of Birth __________________________
(If patient is a minor or dependent)

Privacy Statement

I acknowledge that I have been informed of the Notice of Privacy Practices and the notice is available to me. Upon my request, I will receive a copy of the Notice of Privacy Practices, September 23, 2013 version. I understand that it is my responsibility to read the information provided therein.

Signature: ____Date:________________________________
(If patient is a minor dependent, parent or legal guardian must sign)

Release of Medical Information, Appointments and Prescriptions

If patient is a minor or dependent, **all** parents or legal guardians must be listed below.

Should it become necessary, New Mexico Clinical Research & Osteoporosis Center, Inc. physicians and medical staff have my permission to discuss my health information, including test results, with the individuals listed below. The people that are listed below are also authorized for the above statement regarding appointments and prescriptions. **I understand that if I need to change this information, it is my responsibility to request this in writing.**

Name:____Relationship:_________________________________

Phone No.____ ( ) Home ( ) Work ( ) Cell

Name:____Relationship:_________________________________

Phone No.____ ( ) Home ( ) Work ( ) Cell

Signature:____Date:______________________________________
(If patient is a minor or dependent, parent or legal guardian must sign)

Financial and Credit Policy

I acknowledge that I have been informed of the Financial and Credit Policy and the policy is available to me upon my request. The policy provides me with information pertaining to co-pays, coinsurance, deductibles, No Show and cancellation/reschedules, and the statement process for any outstanding balances due on my account. The policy also addresses my responsibility to **provide 24-hours notice** if I am unable to keep my appointment to avoid a No Show or cancellation/reschedule fee, and the requirement by my insurance company to obtain and provide a doctor's order from my primary care provider for bone density testing. I understand that it is my responsibility to read the information provided therein.

Signature: ____Date:________________________________
(If patient is a minor dependent, parent or legal guardian must sign)

Authorization and Assignment of Benefits

I authorize the release of any medical or other information necessary to process the insurance claim(s) for services rendered by New Mexico Clinical Research & Osteoporosis Center, Inc. (NMCROC). I request payment of authorized Medicare, Medigap or other health insurance policy benefits for services rendered to me by NMCROC be made on my behalf to NMCROC. I request that payment of government benefits, if applicable, to the party who accepts assignment. I understand that even though I may have insurance coverage, I am ultimately responsible for payment of services rendered. I understand that I have the right to revoke this agreement in writing.

Signature: ____Date:______________________________
(If patient is a minor or dependent, parent or legal guardian must sign)