MaxHealth
Family & Sports Medicine

PATIENT'S LAST NAME: _____ **FIRST:** _____ **MI:** ___ **BIRTHDATE:** _____

Financial Disclosure Notice Acknowledgement

I have read the **Financial Disclosure Notice** provided to me and understand my financial obligations. I agree to pay the amounts required of me for any fees or services incurred at ***MaxHealth*.** I am over 18 years of age or I am the parent or guardian of the patient. I give permission for ***MaxHealth*** (Elis Medical Corp.) to bill my insurance (if applicable) and release information to my insurance, if necessary, for payment of claims.

Signature: _____ Date: _____ Relationship to Patient if Minor: _____

Notice of Privacy Practices Acknowledgement

By signing below, you acknowledge that you have received the **Notice of Privacy Practices** and you consent to the use and disclosure of your medical information except as expressly stated below. You understand that ***MaxHealth*** has the right to change its **Notice of Privacy Practices** and that you may contact ***MaxHealth*** at any time if you have any questions.

I hereby request the following restrictions on the use and/or disclosure of my information. I understand that you are not required to agree to my requested restrictions and will notify me, in writing, if my request(s) is denied.

_____

_____

Patient Confidentiality and Treatment of Private Medical Information

1. Please list people (and their relation to you) to whom we may release information about your medical condition and/or treatment. Please include anyone who may pick up prescriptions, reports, x-rays, etc. for you. ***Please note: for minors, the parents &/or legal guardians must be listed below, even if completed by a parent or legal guardian.***

   _____

   _____

2. How can we communicate confidential information (e.g., lab results, referrals, diagnostic test results, billing inquiries)?

   Home phone? ◯ Yes ◉ No **Work phone?** ◯ Yes ◉ No **Cell Phone?** ◯ Yes ◉ No

   E-Mail? ◯ Yes ◉ No Email address: _____

Signature: _____ Date: _____ Relationship to Patient if Minor: _____