DRS. ODOM, COBURN, AND RICHARDSON

1

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Drs. Odom, Coburn, and Richardson's Notice of Privacy Practices.

Patient Name _____

Signature _____ Date _____

****

2

CONSENT TO USE OR DISCLOSE HEALTH INFORMATION FOR THE TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

In the course of providing service to you, receive and store health information that identifies you. It is sometimes necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct health care operations involving our office. We have a comprehensive Notice of Privacy Practices that describes these uses and disclosures in detail. You may refer to the posted copy in the lobby of our office or take a copy with you. When you sign this document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services, and to perform health care operations. You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or health care operations, as described in our Notice of Privacy Practices.

I HAVE READ THIS CONSENT AND UNDERSTAND IT. I CONSENT TO THE USE AND DISCLOSURE OF MY HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

Patient Name _____

Signature _____ Date _____

****

3

ASSIGNMENT OF BENEFITS AUTHORIZATION

Name of Medical Insurance _____ Secondary _____

Name of Vision Insurance _____ Social Security # of Insured _____

ASSIGNMENT OF BENEFITS AUTHORIZATION

I certify this insurance information is true and correct to the best of my knowledge. I will notify you of any changes in my health insurance or routine vision coverage. I request that payment of authorized medical or routine vision benefits be made to Drs. Odom, Coburn & Richardson on my behalf for any services furnished by them. I authorize Drs. Odom, Coburn & Richardson to release to the health plan indicated, any information needed to determine these benefits or benefits payable to related services. I understand that I am ultimately responsible for the balance on my account should my insurance company deny my claim for any reason.

Signature _____ Date _____