ABBEVILLE SURGICAL

FAX PRIVACY WAIVER

I understand that my medical records may be transmitted electronically by fax and may be received in error by a third party. In the event that this should occur I absolve this practice of all liability. I give my consent to fax records for the purposes of treatment, payment or healthcare operations and understand that I may withdrawal this consent at any time in writing.

BILL OF RIGHTS

I have received information regarding the providers of care in this organization, a copy of the Patient's Bill of Rights and Responsibilities, and information regarding the process.

PATIENT CONSENT FORM

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you and your rights with respect to your health information. You have the right to review our notice before signing this consent. As stated in our notice, the terms may change. If we change our notice, you may obtain a revised copy by requesting one from the front desk personnel. The revised notice will also be posted in our waiting room.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent in writing except where we have already made disclosures in reliance on your prior consent.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to the restriction, but if we do, we are bound by our agreement.

By signing this form you also acknowledge that you have receiver or reviewed a copy of the Notice of Privacy Practice.

FINANCIAL POLICY

I certify that I have read the financial policy, and I will comply with this Financial Policy. I acknowledge full financial responsibility for the service provided to me or my minor children by Abbeville Surgical. I understand that I am responsible for prompt payment of any portion of this charges not covered by my insurance, including co-pays, co-insurance, deductibles and non-covered services. I understand that I am responsible for prompt payment of all charges in the event that I do not have health insurance or that Abbeville Surgical is not a participating provider with my health insurer. I consent to the assignment of authorized insurance benefits by the health insurer to Abbeville Surgical for any services furnished to me or my minor child.

My signature below signifies that I received information of the Fax Privacy Waiver, Patient Bill of Right, Notice of Privacy Practice and the Financial Policy

______________________________	______________________________
Signature of Patient or Personal Representative	Relationship to Patient (if applicable)
______________________________	______________________________
DATE	ACCT #