

Greg A. Cisneros, M.D.
33 Old Kings Rd North, Ste #2
Palm Coast, FL 32137
386-446-4141

PATIENT _____ DOB _____ SS# _____

The following form is required by the privacy regulations created as a result of the HEALTH INSURANCE PORTABILITY and ACCOUNTABILITY ACT OF 1996 (HIPAAA)

PATIENT CONSENT AND AUTHORIZATIONS

CONSENT FOR TREATMENT: I, the undersigned patient, parent or legal guardian, do hereby present myself (or the patient) for care or treatment at the office of Dr. Cisneros and voluntarily consent to the rendering of such care or treatment, including performance of diagnostic and/or surgical procedures. I understand that I am under the care and supervision of my physician and it is the responsibility of the practice and its staff to carry out the instructions of such physician. All physicians expect payment in full upon receipt of a bill and I will assist in billing appropriate insurance companies. If insurance or other benefits are involved: I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatments or examination in the office. I understand that I am responsible for the outcomes of care or treatment if I do not follow the care, service, or treatment plan.

ASSIGNMENT OF BENEFITS: I hereby assign payment directly to Dr. Cisneros, the physician accepting this assignment, of all medical benefits applicable and otherwise payable to me. I understand that I am financially responsible to Dr. Cisneros for charges not covered by this assignment or for any and all charges which the insurance carrier declines to pay.

RELEASE OF MEDICAL INFORMATION: I, the undersigned patient, parent or legal guardian, do hereby authorize Dr. Cisneros and his employees to use and/or release certain protected health information to any third party payor (such as insurance company or government agency) any medical, psychiatric, alcohol, drug abuse, and/or HIV (AIDS or AIDS related complex) treatment information and records, in accordance with the policy of Dr. Cisneros and any applicable State or Federal Statues, concerning diagnosis and treatment when requested by such third party payor for its use in connection with determining a claim for payment for such care, treatment and/or diagnosis. I authorize the release of any and all medical information to all physicians involved in my care and treatment. I do hereby release Dr. Cisneros from all liability that may arise from the release of the information requested.

FOR MEDICARE PATIENTS ONLY – CERTIFICATION AND AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary-carriers, any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to Dr. Cisneros. I understand that I am responsible for my health insurance deductible and coinsurance. Medicare does not cover some inpatient, outpatient, and emergency services. Items not covered include, but are not limited to: annual testing and physicals. My signature only acknowledges my receipt of this message from Dr. Cisneros as dated below and does not waive any of my rights to request a review.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Cisneros reserves the right to revise the Notice of Privacy Practices at any time, which may be obtained by forwarding a written request to Dr. Cisneros office. With this consent, Dr. Cisneros or his staff may call my home or other alternative locations and leave a message in reference to any items that assist the practice in carrying out their function, such as appointment reminders, insurance items, and lab results, among others.

By signing this form, I am consenting to allow Dr. Cisneros to use and disclose my Protected Health Information, to carry out treatment, payment, and health care operations. I have the right to request that Dr. Cisneros restrict how he uses or discloses my PHI, but the practice is not required to agree to my requested restrictions. If I do not sign this consent, or later revoke it, Dr. Cisneros may decline to provide treatment to me.

Signature of Patient or Legal Guardian _____ Date _____ Relationship to Patient _____

Print Patient's Name _____ Patient Unable To Sign Due To: _____