

ATLANTA COLON AND RECTAL SURGERY, P.A.
RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have received a copy of ATLANTA COLON AND RECTAL SURGERY, PA's Notice of Privacy Practices.

I consent to the use and disclosure of my protected health information by Atlanta Colon and Rectal Surgery, PA for the purpose of providing treatment to me, obtaining payment for my health care bills, and/or to conduct health care operations.

I understand I have a right to review Atlanta Colon and Rectal Surgery, PA's Notice of Privacy Practices prior to signing this document. Atlanta Colon and Rectal Surgery, PA reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the practice website, calling the office and/or requesting a revised copy by sent in the mail.

I understand that I have a right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or health care operations of the practice. Atlanta Colon and Rectal Surgery, PA is not required to agree to the restrictions that I may request. However, if Atlanta Colon and Rectal Surgery, PA agrees to a restriction that I request, the restriction is binding.

I have the right to revoke this consent, in writing, at any time, except to the extent that Atlanta Colon and Rectal Surgery, PA has taken action in reliance on this consent.

Signature of Patient or Personal Representative

Date

ASSIGNMENT OF BENEFITS

Assignment of Insurance Benefits: I hereby authorize payment directly to Atlanta Colon and Rectal Surgery, PA, of any and all insurance benefits for this visit, hospital inpatient and outpatient stay, otherwise payable to or on behalf of the patient or to me, and authorize release of information requested by the patient's insurance company (ies).

Signature: _____ Date: _____
(Patient or authorized representative)

Assignment of Medicare and/or Medicaid Benefits: I certify that the information given by me in applying for payment under Titles XVIII and XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration or Georgia Medical Care Foundation or its intermediaries or carriers any information needed for this or a related Medicare and/or Medicaid Claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services and authorize such physician or organization to submit a claim to Medicare and/or Medicaid for payment to me.

Signature: _____ Date: _____
(Patient or authorized representative)

Office Use Only:	
Refusal to Sign:	
1. _____ Employee Signature	_____ Date
2. _____ Employee Signature	_____ Date