Dr. Rosann Volmert
OSTEOPATHIC FAMILY PHYSICIAN
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FINANCIAL RESPONSIBILITY AND POLICIES DOCUMENT

I_____ understand that payment is due at the time that services are rendered, and agree to pay in full at that time to Rosann Volmert DO. I agree that the method of payment will be cash, check or credit card (MC or Visa).

- I give Rosann Volmert DO, staff and insurance biller permission to release to my insurance company any and all information necessary for the processing of insurance claims.
- I understand that I am responsible for missed appointments and that Rosann Volmert DO requests 24-hour notice for all cancelled and/or rescheduled appointments.

PLEASE NOTE:

YOU MAY BE CHARGED FOR A MISSED APPOINTMENT IF 24-HOUR NOTICE IS NOT GIVEN.

Signed _____ Date_____

If patient is a minor, state the relationship of the above signed.

_____

(Continued)

Patient Consent For treatment

I,_____ , (the undersigned) do hereby give Rosann Volmert D.O. permission to diagnose and treat until this permission is revoked in writing.

Patient Signature_____Date_____

Date of Birth_____

Witness_____

Patient Consent HIPAA Privacy Notification

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name:_____

Signature:_____Date:_____

Relationship to Patient:_____