

PRIVACY NOTICE

My signature on this document verifies that I have received, read and understand the Privacy Notice of Algology Associates, P.C. as required by law in accordance with the Health Insurance Portability and Accountability Act (HIPAA) effective April 14,2003.

ASSIGNMENT OF BENEFITS

I hereby authorize payment to be made directly to Dr. Sanjiv Parikh, M.D. All benefits payable to me under the terms of my insurance policy with respect to professional services shall be payable to Dr. Parikh. In the event that my insurance company pays me for services rendered, I shall be responsible for remitting such monies to Dr. Parikh.

GUARANTEE TO PAY

I understand that payment is expected at the time of services are rendered to me by the above named physician; unless my injury/ accident is work related or related to a motor vehicle accident.

I authorize and request payment of my benefits for treatment to the above named physician. I understand that any outstanding balance not covered by my insurance will be my responsibility to pay.

Any balance that is not paid within 90 (ninety) days, shall be subject to interest charges. If this account is turned over to an attorney or collection agency to obtain payment, then I shall be responsible for attorney's fees, court costs and any costs incurred by the collection agency. A copy of my signature shall have the same force and effect as the original.

AUTHORIZATION FOR TREATMENT AND MEDICAL RELEASE

My signature below is my consent for medical treatment in the doctor's office during the course of this injury/accident or illness.

I hereby authorize Sanjiv Parikh, M.D. to release medical information in the course of my examination and treatment with the understanding that this information will be used for purposes related to my medical history and care.

Signature: _____
Patient or Policyholder

Date: _____