BETTY JO DULANEY, MD, PC
ASSIGNMENT FORM/HIPAA/ACCOUNT PERMISSION

Assignment and release **Initials** __________

I assign directly to Betty Jo Dulaney, MD, PC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not paid by insurance as well as collection fees or interest that may be added if the account should be placed with an outside collection agency. I authorize the use of my signature on all insurance submissions. Betty Jo Dulaney, MD, PC may use my health care information and may disclose such information to the named insurance company/companies (as listed on the patient registration form) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. Furthermore, I authorize Dr. Dulaney to release my records to other physicians as needed to provide assistance in the course of my care/treatment.

HIPAA **Initials** __________

I am verifying that I have seen the privacy regulation form (HIPAA) posted on the clip board which provides me with the information of how my Protected Health Information (PHI) can be used and I understand that a copy will be made available to me upon my request.

Discuss your account/payments/test results

We cannot discuss your account/payment details/or test results with anyone without your written permission (this includes your spouse or any other family member) unless they have a power of attorney letter on file. By your initial (above) and signature (below), you are giving us permission to discuss your account/payment details/or test results with the listed person(s).

Name of approved person we may talk to:

Name:______________________________ Relationship: _________________________

Name:______________________________ Relationship: _________________________

*****__Leave a message on your Answering Machine__ __________**Accept** ____________**Decline**

PHARMACY INFORMATION (Where would you like prescriptions sent?)

__________________	(_____)__________	_______________________	____________
Pharmacy Name	Phone #	Address	Cross Street

I give permission to obtain formulary information and information about other prescriptions prescribed by other providers provided by PBM and permission to send prescriptions/refills requests though Sure Scripts an electronic prescribing company.

Initials_________

Preferred Communications:

We now offer notifications for general information for appointments/reminders/general non specific lab information/prescriptions. If you would like to start receiving this information please indicate below. Please understand that Texting/ emailing fees from your carrier may apply and you can change or cancel notifications at any time just by letting us know.

___I would like to receive text notifications to cell phone #____________________

___I would like to receive email notifications to email address______________________

___I DO NOT want text or email notifiation

I have read, understand, and give my permission to the above statements including statements that have been initialed.

Patient name: ________________________ Date: ___________________________________

Signature: ____

(Signature of patient, parent, guardian, or personal representative)