Dr. Steven Plotka

Assignment of Benefits and Consent to Treat

I authorize my insurance benefits be paid directly to the physician; if insurance benefits are paid to me, I hereby agree to remit all payments directly to Dr. Plotka. I also authorize Dr. Plotka or insurance company to release any information required to process my claims. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and treatment of my medical attention.

Notice of Privacy Practices Acknowledgement

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 healthcare providers who may be involved in that treatment and follow-up directly and indirectly.

•Obtain payment from third-party payers.

•Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization at any time has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy.

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 healthcare operations. I also understand you are not requires to agree to my request restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature: ____ Date: _______________

OFFICE USE ONLY:

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: ____________ Initials: ______ Reason: ______________________________