LUIS F. PINEDA, M.D., P.C.
CONSENT FOR PURPOSES OF TREATMENT/PAYMENT/HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by Luis F. Pineda, M.D., P.C. for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations. I understand that diagnosis or treatment of me by Luis F. Pineda, M.D. or our CRNP, ________________________ may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Luis F. Pineda, M.D., P.C. is NOT required to agree to the restrictions that I may request. However, the practice will do everything to protect the patient’s confidentiality.

I have the right to revoke this consent, in writing, at any time and seek care at another facility.

My “protected health information” means health information, including my demographic information collected by me and created or received by my physician, another healthcare provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me. The information released may indicate the presence of a communicable or veneral disease, which may include HIV or AIDS.

I understand I have a right to review Luis F. Pineda, M.D., P.C.’s Notice of Privacy Practices prior to signing this document and a copy of this has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations of the Luis F. Pineda, M.D., P.C.

Luis F. Pineda, M.D., P.C. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a copy of the revised version by calling the office and requesting a copy.

I understand that I the patient or another person who specifically agrees to guarantee payment for the patient is responsible for the payment of all charges of the treatment I receive from Luis F. Pineda, M.D., P.C. including co-payments, deductibles, coinsurance payments and non covered charges within 15 days of the billing date. The patient shall pay all cost of collections in connection with the enforcement of this commitment, including reasonable attorney fees, interest and court cost incurred by our facility.

I assign benefits as said below:

Medicare: The patient hereby requests that payment of Medicare Benefits be paid to Luis F. Pineda, M.D., P.C. for services provided.

Physicians: I also assign benefits to all physicians involved in the care I receive at this facility. PLEASE NOTE: Some physician's billing including, but not limited to, Radiology, Pathology, Laboratory, Emergency may be billed separately.

Insurance: The patient hereby assigns to Luis F. Pineda, M.D., P.C. all benefits under any insurance policy, health plan, worker's compensation or other third party payor liable to the patient, in consideration for services rendered by our facility.

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Name of Patient or Personal Representative

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Signature of Patient or Personal Representative

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Date

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Description of Personal Representative's Authority