Patient: ____ Date of Birth: _________________________

Financial Responsibility: I understand that I am personally responsible for all charges that are not covered by insurance. If my account becomes past due, I understand that Metrolina Medical Associates will take necessary steps to collect this debt. Should the collection of the balance be referred to an attorney or a collection agency, I agree to pay all attorneys' fees which are incurred, plus all court costs and collection costs. If covered by Medicare and Medicaid, I certify that the information provided by me in applying for payment under Titles V, XVIII and/or XIX of the Social Security Act is correct.

Assignment of Insurance Benefits: I authorize the release of any medical or other information necessary to process this claim. I also request payment of benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Consent for Healthcare and Release of Medical Information: I voluntarily consent to healthcare treatment from the physicians and staff at this Metrolina Medical Associates facility. I am aware that the practice of medicine is not an exact science. No guarantees have been made to me regarding the result of treatments or examinations by my caregivers. I consent to the use and disclosure of protected health information, about me for treatment, payment and healthcare operations.

Acknowledgement of Receipt of Privacy of Practices:
I have had the opportunity to review a copy of the Metrolina Medical Associates Notice of Privacy Practices.

Disclosure Consent Form: In accordance with the HIPAA Privacy Regulations, applicable state laws, and our Notice of Privacy Practices, Metrolina Medical Associates is required to maintain the privacy of your protected health information. By completing and signing this document you are giving permission for Metrolina Medical Associates to release your health information and account information with the family/caregivers that you have listed below. I hereby give consent for the following family members/caregivers to receive verbal and/or written and/or electronic communications from Metrolina Medical Associates. I understand that sensitive information, like HIV and pregnancy test results, mental health or substance abuse will be shared unless I specify otherwise below:

Do not release information about ____

Release information to:

Name	Phone Number	Relationship
______________________________	_______________________	__________________
______________________________	_______________________	__________________
______________________________	_______________________	__________________
______________________________	_______________________	__________________

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that the information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked or superceded by a new authorization signed by the patient.

Preferred Method of Contact: List Phone# or Email address (fill in blank) _______________________________________

I authorize Metrolina Medical Associates to leave voice messages concerning my health information (test results, appointments/visits, etc.) at the preferred contact listed on my record. I understand that if email is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or electronic communication. I elect to receive communication about treatment alternatives even if this office is being compensated for making the communication. This acknowledgement must be completed and signed by the patient/beneficiary. By signing below, I am agreeing that I have read this document and have had the opportunity to ask questions and my questions have been answered.

____ _________________________
Signature of Patient (or Power of Attorney) Date

For Office Use Only

I attempted to obtain written consent for disclosures of protected health information, but the consent could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining consent
- An emergency situation prevented us from obtaining consent
- Other (specify): ______________________________________

___________________________________ ___________________________________
Employee Signature Date

Revised: Sept 2014