

**Impact 's Privacy and Billing Procedures
Authorization and Acknowledgement**

These authorizations/acknowledgements cover all services rendered to me, or the patient I am signing for, today and all future dates of service. I understand I may revoke this authorization by informing Impact in writing, but if I do revoke this authorization, it will not affect anything prior to the date the revocation is received by Impact.

**Acknowledgement of Receipt of Notice of Privacy Practices
Authorization to Release Information to Family/Friends or Others**

I have received a copy of Impact's Notice of Privacy Practices. I authorize Impact to release any information regarding my treatment; including lab results, x-rays, and medical records, to the following individuals/entities (Impact may not release information or records to the names individuals/entities unless you identify them here):

Name _____ Relationship to Patient _____

Impact will use my home phone number and primary address supplied during registration to contact me regarding my treatment; including lab results, x-rays, and medical records. I will ensure this information is up to date at every visit.

Authorization to Treat and Bill

I consent to be treated by Impact. If I am not the patient being treated, I am authorized to consent to treatment and billing for the patient identified below. I authorize Impact to bill my medical insurance for the care I receive and to release any information the insurance carrier requires to process this bill. I authorize payment of medical benefits to Impact, or to outside labs as described below, for all services performed and billed by Impact. I understand that I am responsible for all charges for the treatment I receive at Impact. I understand that Impact providers may utilize the Prescription Monitoring Program service at no additional charge to me.

As a courtesy, Impact will bill my medical insurance. If I do not provide complete and accurate insurance information to Impact, I understand Impact may not receive payment for my carrier and I will be entirely responsible for my bill. Even after my medical insurance company pays Impact's bill, I may owe Impact payment for services not covered by my insurance and I agree to pay these promptly to Impact. I understand that Impact may send lab specimens to an outside laboratory. I authorize any lab performing services for me to bill my medical insurance for their services. I understand that my medical insurance may not pay for all services provided by the lab and I agree to pay any remaining balance promptly to any outside lab providing services to me. I understand that Impact is not responsible for payment to outside labs for tests provided to me.

To protect my privacy and prevent fraud, I understand that if I cannot provide acceptable photo identification at the time of service, Impact may choose not to bill insurance and may decline credit/debit cards and checks as a form of payment. I understand that if I fail to pay Impact for services provided to me, the balance owed may be sent to collection and I may incur collection fees of up to 25% in addition to the amount owed for services/treatment rendered. I understand that I may contact Impact to work out payment arrangements that may prevent this additional cost.

Signature _____ Today's Date _____

Patient Name _____ Patient's Date of Birth _____

Name of Patient Representative * _____ Relationship to Patient* _____

*(Required if the patient is a minor or if the patient is unable to sign this form.)