martha e. stewart, md, llc
dermatology

ACKNOWLEDGEMENT OF RECEIPT OF NONDISCRIMINATION POLICIES AND NOTICE OF PRIVACY PRACTICES

By providing my name below, I hereby acknowledge that I have reviewed the Nondiscrimination Policies and Notice of Privacy Practices, describing the privacy practices and safeguards as well as my rights with respect to my protected health information maintained and used by Martha E. Stewart, M.D., L.L.C.

By providing my name below, I hereby declare that I have honestly and completely answered the questions that were asked in this form to the best of my knowledge. I understand that it is my responsibility to notify Dr. Martha E. Stewart, Dr. Olivia A. Gioe, and/or the staff of Martha E. Stewart, MD, L.L.C of any changes in insurance coverage, personal information, my medical condition, or medication during the course of my treatments or follow up visits.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Martha E. Stewart, M.D., L.L.C., or any holder of medical information about me to release to the Health Care Financing Administration and its agents (Medicare) or Insurance Companies or Third Parties, any information needed to determine these benefits or the benefits payable for related services.

ASSIGNMENT OF BENEFITS

I request that authorized Medicare or Insurance payments of medical benefits be made to Martha E. Stewart, M.D., L.L.C.

GUARANTOR RESPONSIBILITY

I understand that I am ultimately responsible for payment of any and all charges for medical services rendered by Martha E. Stewart, M.D., L.L.C, and if this assignment is rejected, modified, or not paid within a reasonable time after it has been filed, it will be my responsibility to pay any unpaid charges in full. If it is necessary to collect unpaid fees for services rendered, I agree to pay the charge assessed by the collection service, legal counsel or court.
This authorization and assignment may be revoked by me at any time by a written notice.

I agree that a photocopy of this form may be used in lieu of the original.

By providing my signature below, I acknowledge that all information I have submitted on this form is correct.

Signed By: Patient or Legal Guardian, if a minor _____ Date _____

Print Name _____ Date _____