SWISHER INTERNAL MEDICINE, PLLC

Consent Form

PATIENT ______________________________ DOB ___/___/____

Consent For Treatment:

I hereby give consent to Swisher Internal Medicine to provide whatever treatment the physician/provider may deem necessary to the patient.

Consent For Insurance Policy:

Swisher Internal Medicine will submit claims to the insurance companies that they are contracted with. I understand that I am responsible for all deductibles, copays, and charges not covered by insurance at the time of service. I also understand that I will need to bring my insurance card at each visit along with my cost that the insurance does not pay.

Authorization To Release Information:

I hereby authorize Swisher Internal Medicine to release any information acquired in the course of my treatment to any insurance company including Medicare. I also authorize the payment of claims directly to Swisher Internal Medicine.

Signature for treatment, insurance policy, and authorization to release information:

SIGNED _________________________________ Date ____________

Acknowledgement of Receipt of Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. It also provides information about your rights as a patient of out practice and whom you may contact at out practice to ask questions about our privacy practices. By signing this form, you have agreed that you have had the opportunity to read our Notice of Privacy Practices.

SIGNED _________________________________ Date ____________