Hand & Microsurgery Associates
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PLEASE READ CAREFULLY AND SIGN IN ALL INDICATED SPACES!

Patient Name: ______________________ **(please print)**
Social Security #: ______________________
Date of Birth: ______________________

1. **CONSENT STATEMENT & INSURANCE AUTHORIZATION**
I hereby give my consent to treatment by Hand & Microsurgery Associates. I hereby authorize Hand & Microsurgery Associates to furnish information to my health insurance carrier(s) concerning my illnesses and treatment.

DATE: ___________________ SIGNATURE: ________________________________

2. **ASSIGNMENT OF BENEFITS & FINANCIAL RESPONSIBILITY**
I hereby assign Hand & Microsurgery Associates all payments of medical services rendered to my dependents or myself. I understand that I am responsible for my cost sharing (i.e. copayments, deductibles and/or coinsurance) as defined by my health insurance carrier at the time of services for all expenses incurred during my office visit. My insurance policy is a contract between me and the insurance carrier and it is my responsibility to know the benefits/provisions of my policy. I understand that possession of medical insurance does not relieve me of financial responsibility to Hand & Microsurgery Associates. I also understand that I am ultimately responsible for any and all charges that my insurance carrier applies to my financial responsibility (i.e. deductible/coinsurance, not a covered benefit/service, pre-existing condition denial, etc). I will provide current and accurate information regarding my insurance policy. If I am a Private Pay Patient, I understand that payment in full for all services rendered will be due at the time of service.

DATE:___________________ SIGNATURE: __________________________________

3. **MESSAGE AUTHORIZATION**
I hereby authorize Hand & Microsurgery Associates to leave messages regarding my appointments, care, treatment and/or billing at the following phone numbers:
___ leave a detailed message at ____
___ leave a message with name and number only at__________________________________.

DATE:___________________ SIGNATURE: __________________________________

4. **EMAIL AUTHORIZATION**
I hereby authorize Hand & Microsurgery Associates to leave emails regarding my appointments, care and treatment at the following email addresses:
____.

DATE:___________________ SIGNATURE: _________________________________

5. **HIPPA AUTHORIZATION**
I have the right to revoke this authorization in writing except to the extent that Hand & Microsurgery Associates has acted in reliance upon this authorization. I hereby authorize Hand & Microsurgery Associates to disclose medical information about me or my dependents to include appointments, care, diagnosis, and/or treatment to the following individual(s):

Name: ____________________________________ Relationship to patient: ____________________

Home #____________________ Cell#:_________________________ Work#_____________________

DATE: ___________________ SIGNATURE: _____________________________________