Anna E. Lee, M.D.

A Medical Corporation

Consent Form

Patient Name _____ Date of Birth_____

Please acknowledge the following requests for authorization:

☐ Yes ☐ No I hereby authorize Anna E. Lee, M.D. to provide medical treatment to the patient on this form.

☐ Yes ☐ No I hereby authorize third parties to pay directly to Anna E. Lee, M.D. any insurance benefits due for services rendered on behalf of the named patient.

☐ Yes ☐ No I authorize Anna E. Lee, M.D. to furnish my insurance company and/or third party payers (or their representatives), any medical information necessary to process our insurance claims.

☐ Yes ☐ No I hereby acknowledge that I have reviewed a copy of the Financial Policy and I understand that I am responsible for payment of all charges for medical services rendered to the named patient.

☐ Yes ☐ No As required by the Privacy Regulations, I hereby acknowledge that I have reviewed a current copy of "Notice of Privacy Policy". I have read the Privacy Policy and understand my rights contained in the notice.

☐ Yes ☐ No By way of my signature, I provide Anna E. Lee, M.D. my authorization and consent to use and disclose my child's protected healthcare information for the purpose of treatment, payment and healthcare operations described in the Privacy Policy.

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPPA), you have a right to request that communication concerning your personal health information be made through confidential channels. Anna E. Lee, M.D. will try to accommodate all reasonable requests.

I hereby request the use of the following confidential channels for the communication of information related to my child's personal health, treatment or payment for treatment.

Please indicate preferences:

(_____) _____ Primary Phone Number

☐ Do ☐ Do Not leave detailed messages on my primary answering machine or voice mail

(_____) _____ Secondary Phone Number

☐ Do ☐ Do Not leave detailed messages on my secondary answering machine or voice mail

☐ Do ☐ Do Not leave messages regarding my child's health

☐ Do ☐ Do Not leave messages regarding appointments

☐ Do ☐ Do Not leave messages regarding my child's test results

☐ Do ☐ Do Not leave messages regarding billing

Signature _____ Date _____

Printed Name _____Relationship to patient_____