Myrtle Ridge Family Medicine

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Myrtle Ridge Family Medicine and Jack Bergh, MD to submit claims to my insurance company on my behalf, for services rendered to me and/or my family. I also authorize the release of information, including personal medical information, if pertinent to the payment of insurance benefits.

I understand that I am responsible for any deductibles, co-insurance and co-payments. In the event my claim is not paid by my insurance, I acknowledge that I am personally responsible for payment in full for services rendered.

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Signature of Patient (or Parent) & Date

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Claimant, If Other Than Policyholder

HIPAA NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Myrtle Ridge Family Medicine HIPAA Notice of Privacy Practices.

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Signature of Patient (or Parent) & Date

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AUTHORIZATION FOR RELEASE OF INFORMATION TO INDIVIDUALS

I hereby authorize Myrtle Ridge Family Medicine to release my/my child's personal medical information to the following individuals, with the following restrictions:

Name___________________________________ Relationship____________________________

Name___________________________________ Relationship____________________________

Type of information that may be released: ____

☐ OK to leave medical information on my voicemail

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Signature of Patient (or Parent) & Date