PATIENT AGREEMENT

- I certify that the information provided on the patient history form is true and accurate and that there have been no omissions from my medical history.
- I consent to the taking of clinical photographs in the course of diagnostic and surgical procedures for use for treatment, education, and or research purposes.
- I authorize the release of any medical or other information necessary to process insurance claims and authorize payment of benefits to the treating physician for services provided.
- I agree to be financially responsible for all services rendered by the treating physician. A payment on account or an insurance co-payment is due at the time services are rendered. I will be financially responsible for all charges not covered by my insurance. I will pay all financial obligations in a timely fashion; special financial arrangements can be made in certain circumstances. I accept that delinquent accounts may incur finance, collection, and/or legal charges.

HIPAA PRIVACY NOTICE AND CONSENT to DISCUSS MEDICAL INFORMATION

I,_____(print name), am aware of the HIPPA Privacy Notice and a copy will be available to me at my request.

☐ **NO-** I do not wish to have any of my protected health information discussed with anyone other than myself.

OR

☐ **YES-** Stephen Evangelisti, M.D. and/or the employees of Stephen Evangelisti, M.D. have permission to discuss my medical care with the following designated person(s)*

**friend or family; someone other than your physician(s)*

_____	_____	_____	_____
Name	Relationship	Home Phone #	Cell Phone #
_____	_____	_____	_____
Name	Relationship	Home Phone #	Cell Phone #

_____ _____

Signature of Patient or Patient's Representative Date