Olive Branch Family Medical Center
9075 Sandidge Center Cove
Olive Branch, MS 38654-3514
Phone (662)895-4949
Fax (662)895-6776
www.obfmc.com

Please initial each and sign at the bottom.

AUTHORIZATION TO DISCLOSE PHI

I hereby authorize OBFMC to leave a message and/or discuss my protected health information (PHI), to include account information, test results, scheduled appointments, and information regarding my healthcare with the following people:

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

Please note: Any person that is not listed above will not be able to obtain any information regarding your PHI from this office. Insurance companies and other physician offices do not need to be listed.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

_____ I have been notified of Olive Branch Family Medical Center's Notice of Privacy Practices and been offered a copy of these documents.

CONSENT FOR CARE

_____ I hereby give my consent for treatment to OBFMC. If patient is a minor, authorization will remain in effect until the age of 18 or until written notice is given to OBFMC from guardian.

RECEIPT OF COLLECTION POLICY

_____ I have been notified of Olive Branch Family Medical's Credit and Collection policy and been offered a copy of these documents.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN AND FILE MEDICARE/COMMERCIAL INSURANCE CLAIMS

I authorize OBFMC to file claims to and collect payments from my insurance company for services rendered to me or my dependents until such agreement is terminated in writing. I also authorize the release of any information necessary for claim payments. I understand that I am responsible for balances that are not covered by my insurance, co-pays, deductibles, and co-insurance amounts required by my insurance. Collection costs and legal fees incurred in order to collect a balance owed is the responsibility of the patient and/or responsible party.

Signature:_____ _____ Date:_____
Patient, Parent, or Guardian Relationship

Patient Name _____ Date of Birth _____