**Southampton Osteopathy DBA Erasing Diabetes**
**349 Meeting House lane**
**Southampton, NY 11968**

Date _____

Patient Name_____ Male/Female Date of Birth_____

Marital Status_____ Social Security Number _____

Address_____ Town_____ State/Zip _____

Home Phone_____ Cell_____ Work _____

Primary Insurance Co_____ Policy Holder's Name_____

Insurance Policy ID #_____ Group #_____

Secondary Insurance Co _____ Policy Holder's Name _____

Policy Holder's Date of Birth _____ Social Security #_____

*Medicare Lifetime Signature on File:* I request payment of authorized Medicare benefits made on my behalf to Dr. Stephen Braun, D.O. for any services furnished by the physician. I authorize any holder of medical information about me to release any information to the Health Care Financing Administration and its agents in order to determine benefits-related services. _____ (Initial)

*Insurance Authorization for Assignment of Benefits*: I, the undersigned, authorize my treatment by Southampton Osteopathy and payment of benefits to Dr. Stephen Braun, D.O. for services provided by the physician. I understand I am financially responsible for any amount not covered by my contract. I also authorize release of my health information to my insurance company or their agent. This information will be used for the purpose of evaluating and administering claims of benefits.

*Cancellation Policy:* This office requires 24 hours notice to cancel an appointment. I understand that canceling without proper notice will incur a $50 charge.

**Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations:**
*Maintenance of records:* I understand that as part of my health care Southampton Osteopathy LLC originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as: A basis for planning care and treatment; a means of communication among the health professionals who contribute to my care; a source of information for applying my diagnosis and surgical information to my bill; a means by which third-party payers can verify that the services billed are actually provided; a tool for routine health care operations such as assessing quality and reviewing the competence of healthcare professionals.

*Use and disclosure of records:* I understand and have been provided with a Notice of Information Practices that provides me a more complete description of information uses and disclosures. I understand that I have the following rights and privileges: The right to review the notice prior to signing this consent; the right to object to the use of my health information for directory purposes; the right to request restrictions as to how my health information may be used or disclosed to carry out payment or health care operations.

I authorize payment of medical benefits to Dr. Stephen Braun for services rendered. I am aware that Dr. Stephen Braun does not accept Medicaid nor are its products accepted; I understand that as part of this organization's treatment or health care operation, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses including disclosures via fax and email.

This consent allows my protected health information to be disclosed only to the business associates of this office, as in your insurance carrier or any laboratory if blood work or testing is necessary. Any other disclosure to any other entity will require further consent.

I fully understand and accept the terms of this consent.

Patient's Signature _____ Date_____
Parent or Guardian (child under 18)

FOR OFFICE USE
( ) Consent received _____ on_____ added to medical record_____