Dr. Michael J. Niederkorn & Associates

HIPAA PRIVACY
ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I am giving consent to Dr. Michael J. Niederkorn & Associates for use and disclosure of my protected health information to carry out treatment, payment activities, appointment reminders, and other health care operations. I have the right to revoke this consent at any time by giving written notice to this office.

PATIENTS WITH MEDICAL OR VISION INSURANCE

Our office has attempted to gain information and/or preauthorization from your insurance provider. You will be responsible today for any co-payments and non-covered expenses. In the event your insurance provider determines, when the claim is received, that you were not eligible for insurance coverage at the time of service, or there is an outstanding balance due, **you will be responsible for any and all charges not paid by your insurance provider.**

I have been presented the information above and understand that preauthorization by my insurance provider is not a guarantee of payment on my claim. I also understand that all remaining balances are my responsibility and will be paid to Dr. Niederkorn & Associates within 30 days of notification.

My signature on this form will also serve as a "signature on file" for processing insurance claim forms and show that I understand this office's billing policy.

_____ Printed Name of Patient

_____ Printed Name of Guardian(s) if a Minor

_____ Signature of Patient or Guardian

_____/_____/_____ **DATE**

If you would like your information shared with other people, please list them by name, and check the type of information you are allowing to be shared. It is assumed that the guardian(s) of a minor will be permitted access to both, unless our office is specifically notified in written form.

_____ ☐ Medical ☐ Billing ☐ Both

_____ ☐ Medical ☐ Billing ☐ Both

_____ ☐ Medical ☐ Billing ☐ Both

_____ ☐ Medical ☐ Billing ☐ Both