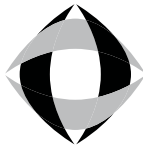


PATIENT AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION & ACKNOWLEDGEMENT OF PRIVACY PRACTICES



DRS. CAMPBELL CUNNINGHAM TAYLOR & HAUN

Patient Name _____ Chart# _____ Date _____

The Patient or Guarantor is responsible for payment in full of all services rendered by the physicians or employees of Drs. Campbell, Cunningham, Taylor & Haun. Payment in full is expected at the time of service unless arrangements are made in advance.

AUTHORIZATION, ASSIGNMENT, AND RESPONSIBILITY OF ACCOUNT

- I hereby authorize Drs. Campbell, Cunningham, Taylor & Haun to release to my insurance companies &/or their intermediaries and/or carriers any medical or other information needed for claims reimbursement.
• I hereby assign, transfer, and set over to Drs. Campbell, Cunningham, Taylor & Haun all medical reimbursement benefits under my insurance policy with above documented insurance companies.
• I hereby acknowledge and accept responsibility for payment in full of all non-covered services rendered to me by Drs. Campbell, Cunningham, Taylor & Haun.

ASSIGNMENT OF MEDICARE BENEFITS

I request that payment of authorized Medicare benefits be made on my behalf to Campbell, Cunningham, Taylor & Haun for any service furnished to me by a physician of the group. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare carrier and I am responsible for the Medicare deductible, co-insurance or the 20% Medicare does not pay, and for any non-covered services.

MEDIGAP OR OTHER SECONDARY INSURANCE

I request that the payment of authorized Medigap benefits be made either by me or on my behalf to Drs. Campbell, Cunningham, Taylor & Haun, or any physician of that group, for services provided to me by a physician of the group. I authorize any holder of medical information about me to release it to my Medigap insurer or any information needed to determine these benefits payable for related services. This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

Signature of Patient/Guardian

Date

HIPAA Privacy Rule gives you the patient the right to request restrictions on uses and disclosures of your Protected Health Information (PHI). You also have the right to request confidential communications or that communications of PHI be made by alternative means, such as sending correspondence to an alternate address or call a different phone number than what is listed. Drs. Campbell, Cunningham, Taylor & Haun have my authorization to contact me in the following manner:

Home Telephone # _____

- O.K. to leave message with detailed information
 Leave message with call back number only
 You may leave a detailed message with anyone that may answer at my residence
 Please only leave a message with _____

Contact Person's Name

Relationship

Work Telephone # _____

- O.K. to leave message with detailed information
 Leave message with call back number only
 Other _____

Written Communications

- O.K. to mail to my home address
 O.K. to mail to my work/office address
 O.K. to fax to this number _____
 O.K. to E-Mail to this address _____

I hereby acknowledge reading Notice of Privacy Practices and understand that I have the right to obtain a paper copy of this notice:

Print Name: _____ Date: _____

Patient / Guardian / Guarantor

Signature: _____ Date: _____