Ferns, Matile, Perryman & Moore, M.D.'s, P.C.
Obstetrics & Gynecology

Patient Name: _____ D.O.B.: _____
Print Patient Name

AUTHORIZATION AND RELEASE

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or other health practitioners.

I authorize and request my insurance company to pay directly to the doctor or doctor's group, insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____ Date: _____
Signature of Patient or Parent/Guardian of Minor

HIPAA

NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGMENT

I, _____
Print Patient Name

☐ have received a copy of Ferns, Matile, Perryman & Moore, M.D.'s, P.C.'s Notice of Privacy Practices.

☐ have been offered a copy and declined

X _____ Date: _____
Signature of Patient or Parent/Guardian of Minor