



TIFFANI KIM INSTITUTE

MEDICAL • WELLNESS • SPA

Patient Consent and Authorization

My signature acknowledges that I have provided complete, accurate information and authorizes the physician to examine and treat me.

- I have received this physician's Notice of Privacy Practices.
- Federal privacy rules permit my personal and medical information to be used and disclosed without my permission for billing, medical treatment and healthcare operations. For other purposes, my information will only be released with my written permission.
- I authorize release of any medical information necessary to process insurance claims, and I authorize payment of medical benefits directly to the physician.
- I understand that all labwork is sent to an outside laboratory and I may be billed separately by the lab and I am able to receive copies of those reports from this office.
- I understand that my insurance company may not cover services due to:
 - Lack of Coverage
 - Non-Covered Services
 - Services not meeting their definition of "medical necessity"
 - Too many services within your insurance carrier's definition of "time period"

I **DO** **DO NOT** request a chaperone in the exam room during the physical portion of my examination.

I have no objection to the doctor and/or his staff discussing my medical treatment with:

Dr. _____ (Primary Care Physician)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I DO NOT OBJECT TO:

- Phone calls to my ___ home ___ place of employment ___ cell phone.
- ___ Messages left on my answering machine/voice mail.
- ___ Messages left with one of the people listed above.

Please note: All mail will be sent to your home address and no information will be FAXed or emailed to you without your written consent.

Printed Name: _____

Signature: _____ **Date:** _____

This practice reserves the right to change its privacy practices as described in the Notice. Revised Notices will be made available upon request.