Acknowledgement of Receipt of HIPAA Privacy Practices and Consent

I understand that as a patient, I have rights and responsibilities. My signature below indicates that I have reviewed a copy of this document and may request a copy for my reference.

Initial: _____

Authorization to Release Billing Information

My signature below indicates that I have reviewed a copy of Treasure Valley Rheumatology's policy; Authorization to Release Billing Information and may request a copy for my reference.

Initial: _____

Assignment of Benefits

My signature below indicates that I have reviewed a copy of Treasure Valley Rheumatology's policy; Assignment of Benefits and may request a copy for my reference.

Initial: _____

Financial Policy

My signature below indicates that I have reviewed a copy of Treasure Valley Rheumatology's Financial Policy and may request a copy for my reference.

Initial: _____

Signature: _____ **Date:** _____

(Patient or Designated Representative)

Print Name: _____

(Patient or Designated Representative)