David S. Nicholson D.O., LLC.
4403 State Route 725 Ste A1 Bellbrook, Ohio 45305
Phone: 937-10-1218 Fax: 937-310-1378

NOTICE OF PRIVACY PRACTICES

I have been notified **"Notice of Privacy Practices"** for my records.

INITIALS: _____

I ____ **DO** ____ **DO NOT** authorize **David S. Nicholson D.O., LLC.** to discuss my appointments, medical evaluations, treatment, my account and results to relatives or other persons as indicated:

NAME: _____ RELATIONSHIP: _____ Phone#:_____
NAME: _____ RELATIONSHIP: _____ Phone#:_____

_____

Patient Signature

FINANCIAL AGREEMENT

I request that payment of authorized benefits be made to **David S. Nicholson D.O., LLC.** I authorize any holder of my medical information to release to the Centers of Medicare and Medicaid Services (CMS) or commercial insurance and their agents any information needed to determine the benefits or the benefits payable for related services.

_____

Patient Signature

I hereby authorize the release of any confidential medical information, including information related to psychiatric care, drug and alcohol abuse, and HIV/AIDS, necessary to process insurance claims or any other medical information that is required for any health care related utilization review or quality assurance activities or to any healthcare professional requiring this information in order to treat me.

I hereby authorize payment to **David S. Nicholson D.O., LLC.** for all medical and/or surgical benefits including major medical policies, to which I am entitled under any insurance policy or policies, any self-insurance program, or any other type of benefit plan. I understand and acknowledge that this assignment of benefits does not relieve me of my financial responsibility for all medical fees and charges incurred by me or anyone on my behalf. I hereby accept such responsibility, including but not limited to, payment of those fees and charges not directly reimbursed to **David S. Nicholson D.O., LLC.** by any insurance policy, self-insurance program or other benefit plan.

This authorization shall remain in effect until revoked by me in writing. A photocopy of this authorizations shall be considered as effective and valid as the original. I understand that I have the right to receive a copy of this authorization.

_____ _____

Patient Signature (or responsible party) **Date**