ASSIGNMENT OF INSURANCE BENEFITS

I HEREBY AUTHORIZE DIRECT PAYMENT OF SURGICAL/MEDICAL BENEFITS to Dr. Ellen Frankel, MD, Inc. for services rendered by her in person or under her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

Signature: ____Date: ____________________

Relationship (if not signed by patient) ____

AUTHORIZATION TO RELEASE INFORMATION

ACKNOWLEDGEMENT NOTICE OF PRIVACY PRACTICES POSTED

(To be filed in patient's medical record)

I HEREBY AGREE THAT THERE IS A Display of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

Signature: ____Date: ____________________

Relationship (if not signed by patient) ____

I wish to place the following restrictions on disclosure of my health information:

____

Internal Use Only

If patient/patient's representative refuses to sign acknowledgement, please document date and time notice was presented to patient and sign below.

Presented on (Date & Time) ____

By (Name & Title) ____

Ellen H. Frankel, MD
Michael A. Bharier, MD
Jacqueline Albrikes, MSN, ANP-BC
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