Itzhak Nir MD, FACS
palms wellington
PLASTIC SURGERY

HIPAA PATIENT CONSENT FORM

This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your health care information.

I hereby give my consent to Dr. Itzhak Nir to use and disclose my protected health information for the purposes of treatment, payment and operations of my health care and this practice.

CONSENT FOR TREATMENT: I, authorize this practice and any employee working under the direction of the physician, to provide medical care for me, or to this patient for which I am legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but limited to) preventive, diagnostic therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body and the sale or dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professionals for care and treatment.

CONSENT FOR RELEASE OF INFORMATION FOR PAYMENT AND OPERATIONS: I also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities.

CONSENT RELATED TO THE PRIVACY NOTICE: I have had a chance to review the Practice Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions.

CONSENT FOR ASSIGNMENT OF BENEFITS: I consent to assign all payment for these services to this practice. I understand that I am responsible for all co-payments, amounts applied to deductibles and other amount that may be deemed my responsibility by the payment sources, as required by my contract with my insurance plan and state regulation. I further understand that my contract with my insurance entity may or may not cover some services. It is my responsibility to obtain information from my health plan about service coverage. If I seek care outside of the contract, I am aware that I may be responsible for all charges that are incurred.

By signing below, I agree to all of the above consents:

Patient/Guardian: _____ Date:_____

I hereby revoke the consent given above. I understand that this practice may refuse me services if I refuse to sign this consent. I may revoke this consent at any time, but the practice may refuse further services at that time.

Patient:_____ Date:_____