RESPONSIBLE PARTY INFORMATION:

Name of Responsible Party: ______________________________

Address: ______________________________

City, State, Zip: ______________________________

Phone: ( ) ______________ Date of Birth: ______________ M ☐ F ☐

Social Security: ______________ Student Status: Full Time ☐ Part Time ☐

Occupation: ______________ Employer: ______________

Address: ______________________________

City, State, Zip: ______________________________

Work Phone: ( ) ______________ ext. ________ Cell Phone: ( ) ______________

Marital Status: Single ☐ Married ☐ Other ☐ E-mail: ______________

Emergency Contact: ______________________________

Relationship: ______________ Phone: ( ) ______________

I authorize release of confidential medical information to the following contact persons:

Name: ______________ Name: ______________

Phone: ( ) ______________ Phone: ( ) ______________

Relationship: ______________ Relationship: ______________

I verify that the above information is correct. I understand that I am financially responsible for all charges, regardless of insurance coverage. I request that payment of insurance benefits be made on my behalf to: Daniel F. Brandt, M.D. for any services furnished to me.

Signature of Patient/Legal Guardian: ______________________ Date: ____________

I authorize Daniel F. Brandt, M.D. to disclose/request my health information including copies of records as necessary to/from:

1. *Any health insurance plan, company of billing service that provides insurance coverage for me for the purpose of payment of charges.*
2. *Consulting and treating physicians, diagnostic facilities, labs, radiology/imaging, outpatient facilities and hospitals and other health providers for the purpose of continuity of care.*
3. *Any insurance company that provides liability insurance coverage for Daniel F. Brandt, M.D. to evaluate clinical performance.*
4. *Any workers' compensation, no fault or administrative proceeding for the purpose of evaluating my medical condition.*

All medical information with no exceptions, will be disclosed/requested as necessary to/from the above. I authorize faxing of information as necessary. This authorization shall cover the period of time from my first visit to my last visit and will end 2 years after the date of my last visit. I permit a copy of this authorization to be used in place of the original.

Signature of Patient/Legal Guardian: ______________________ Date: ____________

Daniel F. Brandt, MD, Inc.

AUTHORIZATION

I authorize the medical staff of Daniel F. Brandt, MD, Inc. to administer such treatment as may be reasonable and necessary in connection with the condition(s) for which I have sought medical care.

I hereby authorize the payments of medical benefits to be made directly to DANIEL F. BRANDT, MD, INC. for services provided by their physicians and medical staff. Authorization is granted to release to my insurance carrier such information as may be necessary for processing of my medical claim(s).

This authorization shall remain in effect unless specifically rescinded or cancelled in writing by the patient. All charges are payable upon receipt of billing. A LATE CHARGE OF 1% per month will be charged on that portion of the "CHARGES" which has been outstanding over 60 days.

Date:______________________

______________________ ______________________

Patient's Name (Print) Patient's Signature

______________________ ______________________

Parent's Name (Print) Parent's Signature

(If patient is a minor)

______________________ ______________________

Name of Insured** Subscriber/ID Number

**If covered by CHAMPUS:

Address of Sponsor: ______________________

(If stationed overseas) ______________________

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Daniel F. Brandt, MD, Inc.

Additional HIPAA Patient Consent Regarding Voice Mail Messages:

With this consent, the office may call my home or other alternative location and leave a detailed message on voice mail in reference to any items that assist Daniel F. Brandt, MD, Inc. in carrying out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

Phone number on which voicemail can be left.

1)______________________________

2)______________________________

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

Signed by: ______________________________ ______________ ____________________

Signature of Patient or Legal Guardian — Date — Relationship to Patient

______________________________ ______________________________

Print Patient's Name — Print Name of Legal Guardian, if applicable

Daniel F. Brandt, MD, Inc.

Copay Promissory Agreement

Dear Patient:

Current Federal Laws and contractual obligations require medical offices to collect Copay from patients when appropriate. As such, our office has a contractual and/or legal obligation to collect Copay from our patients when due.

I, ________________________, understand that my insurance company requires Copay be paid for healthcare service provided to me or my dependent. I promise and attest that I will pay the required Copay as determined by my insurance to Daniel F. Brandt, MD, Inc. within thirty (30) calendar days from the date of the bill from this office.

I also understand that failure to make the required payment may result in collection proceedings.

Signature: ____________________________________ Date: ______________________

Patient's name if different than signer: ____

DANIEL F. BRANDT, MD., INC.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this health information can and will be used to carry out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS. I have received, read and understand Daniel F. Brandt, MD, Inc.'s ("THE PRACTICE") *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that THE PRACTICE has the right to change its *Notice of Privacy Practices* from time to time and that I may contact THE PRACTICE at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I hereby give my consent to THE PRACTICE to use and disclose Protected Health Information ("PHI") about me to carry out treatment, payment and health care operations.

With this consent, THE PRACTICE may mail to my home or other alternative location any items that assist THE PRACTICE in carrying out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, such as appointment reminder cards and patient statements.

By signing this form, I am consenting to allow THE PRACTICE to use and disclose my PHI to carry out treatment, payment, and health care operations.

I have the right to request that THE PRACTICE restrict how it uses or discloses my PHI to carry out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS. THE PRACTICE is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I understand I may revoke my consent in writing except to the extent that THE PRACTICE has already made disclosures in reliance upon my prior consent. I understand that if I do not sign this consent, or later revoke or restrict it, THE PRACTICE may decline to provide treatment to me.

Signed by: ______________________________ ______________ ____________________

Signature of Patient or Legal Guardian | Date | Relationship to Patient

______________________________ ______________________________

Print Patient's Name | Print Name of Legal Guardian, if applicable