

# O'Carroll & Associates, L.L.C.

## Patient Authorization

Please initial the following:

           **Privacy Notice**

I acknowledge that I have received a copy of the Notice of Privacy Practices from O'Carroll & Associates, LLC, today.

           **Release of Information and Assignment of Benefits**

I hereby authorize O'Carroll and Associates, LLC to release information to anyone listed on the patient registration form or this authorization form, as well as any of my insurance companies when necessary to complete my claims. I request payment of authorized health insurance benefits (Medicare, all commercial insurance, Medicaid, etc.) be made to either me or on my behalf to O'Carroll & Associates, LLC for any services furnished by that institution. I accept responsibility for all charges not covered by insurance or other third party payers and all costs incurred in or related to the collection of such charges, including but not limited to reasonable collection agency charges, not to exceed 50% of the principle, attorney's fee and cost of suit. **I am responsible for my co-pay at the time of service.**

Other than the patient or parent/guardian or anyone listed on the Patient Registration Form, who is authorized to receive information: \_\_\_\_\_

           **Consent to Treat**

I hereby authorize the consent to the administration and performance of such medical treatments and diagnostic procedure as may be deemed necessary during the course of my appointment by my physician or his/assistants. I understand that not following medical advice and treatment recommended by my doctor may cause or contribute to poor outcomes, This consent will be updated yearly.

           **Authorization to Discuss My Account**

It is the policy of O'Carroll & Associates, LLC to call our patients to confirm appointments for future dates, to reschedule appointments and to inform you when tests results are in. When we call you, we may leave a message on your answering machine or speak with whoever answers the phone. Your initials in this section indicate that this is acceptable to you. If this is NOT acceptable, please let us know at registration.

           **Cell Phone Use**

By providing us with your wireless/cell phone number, you are hereby granting us, and our agents or independent contractors, your consent to **receive calls or text messages** on your wireless/cell phone number for appointment and billing purposes.

My signature indicates my knowledge of and agreement with all of the above:

\_\_\_\_\_  
(Signature of patient or authorized representative)

\_\_\_\_\_  
(Date)