Henderson Pulmonary & Sleep Medicine

568 Ruin Creek Road Suite 127
Henderson, North Carolina 27536
Telephone: (252) 430-7110

AUTHORIZATION AGREEMENTS

ASSIGNMENT OF BENEFITS

I hereby authorize Henderson Pulmonary & Sleep Medicine to apply for benefits on my behalf for services rendered by any of its providers or by their orders. I request that payment from my insurance company(ies), including from the Health Care Financing Administration, be made directly to Henderson Pulmonary & Sleep Medicine (or the party who accepts assignment). I certify that the information I have reported with regard to my insurance coverage is correct. I am financially responsible for charges not covered by this assignment. I permit a copy of this authorization to be used in place of the original. Either my insurance company or I may revoke this authorization at any time in writing.

_____ (Signature) _____ (Date)

RELEASE OF INFORMATION

I authorize Henderson Pulmonary & Sleep Medicine or its agents to release personal medical information needed to determine insurance benefits payable for related services. I also authorize the release of my personal medical information to any physician involved in my care, when necessary to ensure the continuity of care. I permit a copy of this authorization to be used in place of the original. This authorization is in effect until I chose to revoke it in writing.

_____ (Signature) _____ (Date)

AUTHORIZATION FOR COMMUNICATION

I hereby authorize Henderson Pulmonary & Sleep Medicine to communicate in person or by message through the phone numbers, address(es), and e-mails I have provided. I understand that simple information such as appointment reminders may be left with people other than myself or by electronic means (e.g. answering machine). Detailed information regarding my health or financial status will only be communicated to me in person. I understand that I may limit this communication at any time by providing a written request.

_____ (Signature) _____ (Date)

ACKNOWLEDGEMENT OF REVIEW OF PRIVACY NOTICE

I hereby acknowledge that I have reviewed a copy of Henderson Pulmonary & Sleep Medicine's Privacy Policy Notice. I understand that I may request a copy of it at any time.

_____ (Signature) _____ (Date)