PRACTICE NOTICES

FINANCIAL AGREEMENT: The undersigned hereby authorizes the release of any and all information or documents to all parties related to obtaining my insurance benefits for claims submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician and all necessary parties to submit claims to obtain benefits for services rendered without obtaining my signature on each claim submitted for myself and/or dependents. I hereby authorize my insurance company to pay and hereby assign benefits directly to Manatee Physician Alliance, LLC. I further acknowledge that any insurance benefits, when received and paid, will be credited to my account, in accordance with my insurance company's assignment. Any unpaid charges are my responsibility in accordance with any contractual agreements with my insurance and when governed by state/federal law. Full payment is due at the time of delivery of service unless other arrangements have been made or mandated by law. I understand that I have the primary duty and obligation to pay my doctor for his/her services, notwithstanding any contract I may have with any third party payer (i.e. insurance company, employer, etc.). I understand that as a recipient of medical care I, the undersigned, am responsible for all charges regardless of my circumstances for reimbursement.

HIPAA DISCLOSURE: By signing below, I understand that Manatee Physician Alliance shall not publish or otherwise make generally available any protected individually identifiable health information or data that identifies a patient for purposes other than treatment, payment or other health care operations without his/her express written consent. I understand that this does not restrict the internal use of such information or data that is required in the performance of the scope of work that this office has been engaged to perform for patients. I understand that this office maintains physical, electronic, and procedural safeguards to protect individually identifiable health information. As a patient of Manatee Physician Alliance, I understand that I have the right to request special privacy protections. I have the right to request restrictions on certain uses and disclosure of my health information, by written request specifying what information I want to limit and what limitations on use or disclosure of that information I wish to have imposed. I hereby acknowledge that this medical practices' Notice of Privacy Practices has been made available to me. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of this notice.

Signature of Patient or Responsible Party	If person signing is not patient, please state relationship	Date