DENVILLE DIAGNOSTICS

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Patient Consent Form

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal information is protected for privacy. The "Privacy Rule" was also created in order to provide a standard for certain healthcare providers to obtain their patients consent for uses and disclosures of Health Information about the patient to carry out treatment payment or healthcare operations.

As our patient, we want you to know that we respect the privacy of your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients) and may have to disclose personal health information for the purpose of treatment, payments, or healthcare operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refusal of all or part of your (PHI). You may not revoke actions that have already been taken which relied on this or previously signed consent.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Insurance Consent Form

By signing this form, I am verifying that all of my insurance information is valid and up to date.

The insurance cards given to this facility are current and active cards and the proper information has been given in regards to the insurance holder's information, for example: Name, DOB, and/or Social Security Number.

By signing this form, I am verifying that the proper actions were performed in regards to obtaining and authorization number, pre-certification number, and/or referral.

I understand that if an authorization number, pre-certification number, and/or referral was needed in order to have the exam and was not obtained before the time of services that I will be held responsible for the balance of the bill if the insurance company denies the claim.

I confirm that I have read over all of the above information and I believe everything to be true to the best of my knowledge

(PRINT) Patients Name: _____

Signature of Patient and/or Legal Guardian:_____ Date:_____/_____/_____

Can we leave a message on your home phone number? _____YES _____NO

Can we leave a message on your cell phone number? _____YES _____NO