**MEDICAL INSURANCE AND FINANCIAL RESPONSIBILITY**

1. **ASSIGNMENT OF BENEFITS: I authorize payment of medical benefits to the named provider for professional services rendered.**
2. **RELEASE OF INFORMATION: I authorize the release of any medical information necessary to process insurance claims.**
3. **FINANCIAL RESPONSIBILITY: I accept full financial responsibility for any charges for medical services provided. This includes financial responsibility for appointments cancelled with less than 24 hours notice!**
4. **CONFIDENTIALITY: With the exception of the information released for insurance purposes, I understand all information on this form and discussed at any time with Carole Maguire cannot be released without a release of information form dated and signed by me.**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Notice of Privacy Practices Receipt**

**and Acknowledgement of Notice**

**I hereby acknowledge that I have received and have been given an opportunity to read a copy of Carole Maguire’s Notice of Privacy Practices. I understand that if I have any questions regarding the notice or my privacy rights, I can contact her.**

**Patient/Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**