Robert Rundorff, MD, PC
Board Certified
Physical Medicine and Rehabilitation

Consent for Treatment, Records Release, and Assignment of Benefits Form

Before you begin treatment, the law requires that we explain your rights and responsibilities while a patient at our clinic. If you have complaints or concerns about your care, please discuss it first with you the doctor or your primary care provider. If your concern remains unresolved, you may file a complaint with the Privacy Officer/Office Manager. If still not resolved you may file a report to The Department of Health and Human Services.

Consent for treatment: By signing this form, I consent to and authorize my health care provider to examine and treat me. I understand that my provider is available to explain the purpose of the procedures and treatment, and that I have the right to refuse the recommended treatment. No guarantee or assurance has been made to the results that may be obtained.

Agree to the terms of Financial Policy: Which I have reviewed.

Release of Medical Records: I understand that it is important that my providers have access to medical records which will help them to safely treat me and manage my care. I also understand that they will release medical information to contracted providers and medical transcribers for purposes of medical care and business operations. Evaluations and test results generated at this office will be automatically mailed to your referring physician. In many instances a third-party payer or attorney will pay a portion or all of my medical bills. In order for a third-party payer to pay the bills related to my visits at this office, they may require chart notes be forwarded to them. I authorize Robert Rundorff, MD/William Bergin, DO to release any information to determine the payments related to the medical treatment I receive.

Insurance/Medicare/Medicaid Assignment of Medical Benefits: I would like a "third party payer" to pay the bills for my services at Robert Rundorff, MD, PC, to the extent the Payer is required to do so under my policy of insurance or the law. Therefore, I request that payment of my bills by the "third party payer" be made to Robert Rundorff, MD, PC on my behalf for any services furnished to me. I assign the benefits payable for services to the provider or organiz.ation furnishing the services. In addition, I agree to pay for all charges not covered by a third-party payer.

Consent to the use and disclosure of health information for treatment, payment, or operations: I acknowledge that I have been made aware of the privacy practices of Robert Rundorff, MD, PC, if I would like **a** copy of this notice I may ask for one, the notice is also posted in the reception area. I also understand that I have the right to revoke this consent, in writing, at any time except where this office has already made disclosures in reliance on this consent. Robert Rundorff, MD, PC is not required to agree to all the restrictions requested. I understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations. Robert Rundorff, MD, PC reserves the right to change their notice and practices, in accordance with Section 164.520 oft.li.e Code of Federal Regulations. I understand that as part of this organizations treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosures for these permitted uses, including via fax.

By signing below, I agree to the above statements.

Signature of patient/other: _____ Date: _____

Printed name: _____ Patient Date of Birth: _____

If other, relationship to patient: _____

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