RELEASE OF MEDICAL INFORMATION

I hereby authorize Privium Consultants LLC to release medical information to Medicare, my employer's Benefits Department, or my other insurance company for the sole purpose of obtaining payment for my medical care. Although medical information is confidential, many carriers require medical documentation prior to my payment for services. I understand that only information pertaining to obtaining payment for my care will be released. I agree that a copy of this release may be used in place of the original. I am aware that I may request this release of medical information to be revoked at any time by providing the physician's office with a dated and signed letter. I have read and agree to these terms.

AUDIO/VIDEO RECORDING PROHIBITED

Please be advised that, to better enable us to assure compliance with HIPAA Privacy and Security laws and regulations, and in recognition of the legitimate privacy concerns of our patients and staff, the use of any audio or video recording devices in this office by patients or other visitors, including but not limited to cell phones, is strictly prohibited. We reserve the right to terminate any patient as permitted under State lawif the patient or anyone accompanying the patient is found to be in violation of this office policy. We appreciate your understanding and cooperation.

PAYMENT FOR MEDICAL SERVICES

I hereby assume financial responsibility for all changes incurred for services rendered. I understand that I will be required to pay co-payments, amounts applied to deductibles, and balances of bills not paid in accordance with the benefits of my current insurance policy. If I am unable to make payments in full for my medical treatment within 30 days, I agree to call the business office to make payment arrangements.

I hereby authorize payment for all medical insurance benefits which are payable under the terms of my insurance policy to be directly paid to Privium Consultants LLC, or designate payment for services rendered. I certify that the information I have reported regarding my insurance coverage is correct. I authorize the doctor's office to verify insurance coverage and benefits allowed in accordance with my insurance company's policy.

I understand that it is my full responsibility that any third party which I direct Privium Consultants LLC to bill, in the event of non-payment for whatever reason in accordance with the benefits of my current insurance policy, I will pay immediately. It is further agreed that if I fail to pay upon demand, my account will be referred to an outside collection agency or an attorney. I accept full responsibility to pay all collection costs not to exceed 30% and interest of 1.25% per month not to exceed 18% annum and reasonable court costs.

Please sign below that you understand this information.

_____ _____

Patient Date