RELEASE OF INFORMATION

I authorize Dr. Matthew H. Conrad to release any information to any physician involved in my care, hospital, and/or my insurance company including the diagnosis and the records of any treatment for examination rendered to me during the period of such medical and surgical care.

Signature: Patient and/or Guardian ______________________________ ***Date*** ________________

ASSIGNMENT OF BENEFITS

I authorize and request payments of insurance benefits directly to Dr. Matthew H. Conrad otherwise payable to me. I further certify I have provided Dr. Matthew H. Conrad a complete list of the insurance companies with which I have medical and/or surgical coverage. I authorize third parties to pay directly to the physician insurance benefits due for services rendered on behalf of the patient.

Signature: Patient and/or Guardian ______________________________ ***Date*** ________________

INSURANCE

It is the patient's responsibility to provide Dr. Conrad's office with current insurance information. Kansas's law states that clean insurance claims should be paid within 30 days from receipt (K.S.A. 40-2442). Please call your insurance company if your bill is not paid promptly. Medical surgical patients who do not have insurance must make payment arrangements prior to surgery. Our staff will estimate your surgical and laboratory fees. If your insurance requires use of a specific lab, it is your responsibility to notify us. Please check with your insurance company to ensure Dr. Matthew Conrad is in network.

OUT OF NETWORK/UNAUTHORIZED COVERAGE

I understand that the services I am requesting to be rendered by Dr. Matthew H. Conrad may be out of network or unauthorized by insurance (HMO/PPO/PPC/POS/Indemnity/Auto Insurance/Workman's Compensation/Medipass/Coventry, etc.). I understand that if Dr. Conrad is out-of-network, I will be held responsible for all charges. I also understand if I am receiving services from an out-of-network provider, any payment(s) made on the part of insurance company may and or will be made directly to me. I, in turn, agree to sign over the payments to Matthew H. Conrad, MD.

Signature: Patient and/or Guardian ______________________________ ***Date*** ________________

REFERRALS

If you have an insurance plan that requires you to have a referral to be seen in our office, it is your responsibility to obtain a referral from your primary care physician and ensure our office has a current copy. If our office does not have a current referral on file, you will need to sign a self-referral form at the time of your appointment stating that you will be responsible for payment in full for that days services. If you do not wish to sign a self-referral, you may be asked to reschedule your appointment until you can get a referral from your primary care physician.

Signature: Patient and/or Guardian ______________________________ ***Date*** ________________

NOTICE OF PRIVACY POLICY

Although our office has always treated medical records as confidential, our government now wants you to receive a written copy of how this office protects your health records. A written copy of our privacy practices is available for you to take home and read at your convenience, as well as posted in our office. Additionally, please sign this acknowledgment form indicating that we have provided this information to you.

Signature: Patient and/or Guardian ______________________________ ***Date*** ________________

Employee Signature ____