Colleen Campbell, M.D.

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(813) 200-7717 Phone	(813) 200-7717 Phone
(813) 985-8500 Fax	(813) 985-8500 Fax

PERMISSION FOR TREATMENT

I hereby give Dr. Campbell, and all associated healthcare personnel, permission to provide medical treatment as necessary.

STATEMENT OF FINANCIAL RESPONSIBILITY

Dr. Campbell may bill my insurance company and/Medicare for services provided to me; and as such, Dr. Campbell may release my personal health information for processing of such claims. Therefore, I will provide complete, correct and current insurance information at every office visit or when any changes occur.

It is my responsibility to be familiar with all the services covered by my insurance plan and I will pay to Dr. Campbell the fees and costs, including deductibles and co-payments, not covered by the plan.

I understand that Dr. Campbell will make every effort to bill and recover payment on my behalf; however, the ultimate responsibility for payment of rendered services is mine. Any unpaid balance is due within thirty (30) days of receiving statement.

I HAVE RECEIVED THE PATIENT RIGHTS AND RESPONSIBILITIES FORM (see form)

NOTICE OF PRIVACY PRACTICES

Representatives of Dr. Campbell have provided me with its Notice of Privacy Practices which describes how she utilizes and discloses “Protected Health Information”. I understand that I may review this document before signing this form. The terms of The Notice of Privacy Practices may be changed at any time but patient may obtain a copy of the revised notice from the office manager upon request.

I give my consent to release my Protected Health Information to the following individual(s):

(1) ____

(2) ____

Print Patient’s Name: ______________________________ D.O.B: __________

Patient’s or Guardian’s Signature: ____

Relationship to Patient: ____

Date: _____________________________