

Patient Acknowledgement Form

Patient Name:
Patient DOB:
Patient SSN:

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process claims submitted by the above named medical practice, clinic or provider. I also request payment of government benefits either to myself or to the party who accepts assignment below.

I further acknowledge that I have read a copy and that I understand the notice regarding the handling of my healthcare information.

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Signature of Patient or Authorized Person

Date

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Print Name of Person Signing Form

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits directly to the above named medical practice, clinic or provider.

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Signature of Insured or Authorized Person

Date

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Print Name of Person Signing Form