Notice of Privacy Practices

Authorizations: List any persons to whom you WILL allow access of your medical records and/or information concerning your healthcare.

Name ________________________________ Relationship __________________________

Name ________________________________ Relationship __________________________

Patient Authorization

OurMed wants to assist you in the financial management of our relationship. Benefit verification will be provided as a courtesy and is not a guarantee of payment. Be assured that we will be ethical and fair concerning any billing or collection concern you may have. If you have any questions, please speak with our Central Business office at 334-801-9100.

I hereby consent to rendering of medical care, which may include routine diagnostic procedures, laboratory testing, medical and/or surgical procedures performed by authorized physicians and/or staff members of OurMed.

I understand terms are for services rendered. I will be responsible for all charges incurred by me and/or my dependents. Should collection proceedings become necessary, I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and/or court cost, if such be necessary.

Consent to Call

You agree, in order for us to service your account or to collect monies you may owe, OurMed and /or our agents may contact you by telephone at any number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable. I hereby assign to authorize payments directly to OurMed. If the insurance is filed by OurMed, I realize the insurance benefit may not pay the entire bill and agree to pay the difference on the entire bill, if necessary. I authorize the release of any medical information necessary to process my insurance claims or to continue my medical care. I acknowledge that I have been provided access to the notice of privacy Practices of OurMed. Notice of Privacy Practices explains to me use and disclosure of my protected health information (PHI), and a copy is available at my request.

I/We have read this disclosure and agree that OurMed, it employees and/or agents may contact me/us as described above.

I give permission to be contacted in the following manner (please fill in phone numbers and check all that apply) concerning appointments, laboratory results, referrals or other information concerning my healthcare.

Home Telephone # _________________________ Cell Phone # ___________________________

☐ Ok to leave message with information

☐ Leave message with call-back number only

☐ Ok to leave message at home or on the cell number with the following family members:

Name __________________________________ Relationship ___________________________

Name __________________________________ Relationship ___________________________

____ ___________________________

Responsible Party Signature Date