



MED-READY HOUSECALLS

_____ I authorize the release of my medical records to Med-Ready Housecalls upon its request, including all examinations, diagnoses, laboratory and imaging studies, and treatments for the past two years.

_____ I authorize payment of my medical benefits to Med-Ready Housecalls for services rendered.

_____ I authorize Med-Ready Housecalls to give my insurance company any information about services rendered to me as necessary to process claims.

_____ I acknowledge that I received or was offered the practice's Notice of Privacy Practices describing the use and disclosure of confidential healthcare information.

_____ I understand and agree that I am financially responsible for all charges for services rendered to me, including balances owed after insurance payments.

Date

Signature of patient or patient's Power of Attorney

(Please print name above)

Fax complete forms to 916-771-2507

