TRUNG HOA PHAM, MD, LLC
Diplomate of the American Board of Internal Medicine

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided with an opportunity to review it.

Name: _____ Birth date: _____

Signature: _____ Date: _____

AUTHORIZATION FOR USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION ACKNOWLEDGEMENT

I hereby authorize the use or disclosure of my protected health insurance as described in my Authorization Form on record.

Name: _____ Birth date: _____

Signature: _____ Date: _____

PATIENT'S INSURANCE AUTHORIZATION AND ACKNOWLEDGEMENT

I authorized TRUNG HOA PHAM, MD, LLC to apply for benefits on my behalf for services rendered by TRUNG HOA PHAM, MD, LLC. I request payment for my insurance company be made directly to TRUNG HOA PHAM, MD, LLC. I certify the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claims. This authorization may be revoked by me at anytime in writing.

I understand that the benefits quoted to this office by my insurance company are not a guarantee of payment. Any co-payment, co-insurance, or deductible due will be my responsibility.

I understand that nothing herein relieve me of the primary responsibility and obligation to pay for medical services provided when a statement is rendered.

Name of Subscriber of Beneficiary: _____

Signature: _____ Date: _____