Family First Health Center

Delicia M. Haynes, MD

Insurance Information:

Payment for services rendered is to be made as follows:
"I request the payment of authorized insurance benefits be made to Dr. Delicia M. Haynes for any services or items furnished to me by the physician or supplier. I authorize the practice to release to the health care financing administration (HCFA/CMMS), my insurance carrier, and/or its agent's appropriate information needed to determine these benefits or the benefits payable for related services, in accordance with HIPPA guidelines. Release of other information requires specific release authorization. I am financially responsible for appropriate deductible, copayments, and non-covered items (which have been explained to me from information supplied by my carrier). If this account has to be turned over to an attorney due to delinquency or non-payment, I will be responsible for all costs collection including the court costs and attorney fees."

_____ _____
Signature of Beneficiary or Person Signing for Beneficiary Date Signed

_____ _____
Street Address, City, State, Zip of Person Signing for Beneficiary Relationship

Reason Beneficiary is unable to sign _____

Dissemination of Medical Information:
To whom may we, as your health care provider(s), release information about your medical condition(s)?

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Signature of Responsible Party Date Signed

I, the undersigned, or as the parent or legal guardian of the undersigned authorize Dr. Delicia M. Haynes to render medical treatment to myself or the patient above for whom I am responsible.

Signature _____ Date _____

I, the undersigned, confirm that I have read the privacy policy of Dr. Delicia M. Haynes dated _____, which is included in this registration packet.

Signature _____ Date _____