PHYSICIANS' CLINIC
of Iowa, P.C.

Patient Name: _____

Patient DOB: _____

Patient Authorization and Acknowledgement

Assignment of Benefits

I declare under penalty of perjury under the laws of the State of Iowa that the registration information I've provided is true and correct and I further understand substantial consequences can result from providing false information.

ASSIGNMENT OF BENEFITS: In the event they file insurance on my behalf, I hereby assign all medical benefits to which I am entitled to Physicians' Clinic of Iowa, PC (PCI). I have read the PCI Financial Policy and understand I am financially responsible for all charges whether paid by insurance of not. I hereby authorize PCI to release all information necessary to secure the payment of benefits. A copy of this assignment shall be considered as effective and valid as the original.

Patient Name: _____ Patient Date of Birth: _____

_____ _____

Signature (Patient or Patient Representative) Date

Acknowledgement for Receipt of Notification of Information Practices

I, the undersigned, had a copy of Physicians' Clinic of Iowa, PC Notice of Information Practices made available to me.

Patient Name: _____ Patient Date of Birth: _____

_____ _____

Signature (Patient or Patient Representative) Date

Authorization to Share My Health Information

I authorize Physicians' Clinic of Iowa, PC to share my health information with the following individual:

_____ _____ _____ _____

Name (Please Print) Date of Birth Relationship Telephone Number

_____ _____

Signature (Patient or Patient Representative) Date

These authorizations will remain in effect until revoked in writing by the patient