# CALALLEN MEDICAL CLINIC

## DESIGNATED INDIVIDUALS AUTHORIZATION FORM

I hereby authorize one or all the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

**Please Initial next to the statements below.**

_____ I have received/read a copy of Calallen Medical Clinic's Notice of Privacy Practices

_____ I understand Calallen Medical Clinic does not accept workman's compensation and that insurance may deny coverage for any problem that may be determined to be work related and I will be personally responsible for my medical bill.

_____ If my insurance has determined I have a pre-existing condition and they will not pay these claims, I understand I will be personally responsible for the charges.

_____ Similar to hotel reservation requirements, I understand Calallen Medical Clinic reserves the right to add a fee up to $75.00 for any missed appointments (or $150 for physicals/procedures) or failure to cancel with at least 24 hour notice.

_____
Patient Name

_____
Patient Signature

_____
Date

By signing this I agree to all of Calallen Medical Clinic's policies regarding confidentiality and financial responsibilities. I request that payment of authorized insurance benefits be made on my behalf to the provider indicated for any services furnished to me. I understand that I am financially responsible for all charges whether or not covered by insurance.