



JACK ZOLDAN, M.D., LTD

BOARD CERTIFIED INTERNAL MEDICINE
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AUTHORIZATIONS & PATIENT ACKNOWLEDGEMENT

CONSENT FOR TREATMENT

I hereby authorize and consent to treatment provided by *Jack Zoldan, M.D., LTD*, his employees or designees and authorize medical services, diagnostic procedures and medication as deemed necessary or advisable by the caregiver(s) providing treatment. I understand that no guarantee has been made as to the results of the care, treatment, and/or medications, which may be given to me. I authorize *Jack Zoldan, M.D., LTD* to retain any specimen or tissue that may be removed from my body during treatment or dispose of that specimen. I understand that such specimens may yield products or results that give economic benefits to the persons performing the research. I have not been promised any personal benefit from such research. I consent to the use of all unused specimens taken from and I relinquish all right of ownership and interest in the specimens taken from me. This consent shall remain in effect until I choose to revoke it in writing. () Patient's Initials

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize *Jack Zoldan, M.D., LTD* to release any information required in the processing of application for financial coverage for services rendered. This authorization provides that my physician or my physicians' staff may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent. This authorization also includes any medical records containing information related to HIV (AIDS) testing and/or psychiatric care rendered to me if such records are release to an insurance company writing Life, Accident or Health Insurance or a Non Profit Health Care Service Plan Corporation to evaluate my claims or its liability under such policies or contracts or coordination benefits pursuant to such policy or contract provisions. The information obtained will be treated as privileged and confidential and will not be released to any person without my expressed or written consent. Correspondence and test results will only be released to health care providers involved in my care. () Patient's Initials

ASSIGNMENT OF INSURANCE BENEFITS/PAYMENTS GUARANTEE/COLLECTION FEE

I hereby authorize payment to be made directly to *Jack Zoldan, M.D., LTD* for insurance benefits payable to me. I understand that I am financially responsible to *Jack Zoldan, M.D., LTD* for any covered or non-covered services, as defined by my insurer, which are not paid by my primary or secondary insurer. I also understand that if my account balance becomes overdue I agree that any amount not paid within 30 days of billing shall bear interest at the rate of 1.5% per month (18% annually) and if the overdue account is referred to a collection agency, a collection fee, not to exceed 33.3% of the overdue balance, may be added to the amount due and that I am financially responsible for the added collection fee and any reasonable attorney's fees and other costs incurred for collection. () Patient's Initials

MEDICARE

Patient's Certification, Authorization to Release Information, and Payment Request. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf directly to *Jack Zoldan, M.D., LTD*. () Patient's Initials

NOTICE OF PRIVACY PRACTICES - NPP

I, hereby acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information. I understand that *Jack Zoldan, M.D., LTD* has reserved the right to change their privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available. () Patient's Initials

PATIENT ACKNOWLEDGEMENT

I have read the Agreement and Authorization form and I understand its contents and that I have had an opportunity to discuss its contents to my satisfaction. I understand that my signature represents agreement with the contents of the form and that any statement may not amend to contents of the form. My initials { } indicate that I fully accept and acknowledge the contents of each section of this form. I understand that the records/information released will not further disclosed for any purpose other than as stated in this Authorization. () Patient's Initials

Patient Name (Please Print) Patient Signature DOB Date

Patient Representative (Please Print) Signature of Patient Representative DOB Date

Reason Patient is unable to sign and needs a Representative (Please Print)

Relationship of Patient Representative to the Patient (Please Print)