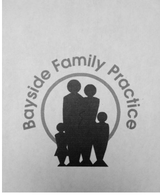

BAYSIDE FAMILY PRACTICE, L.L.C.

JENNIFER HOLLYWOOD, M.D.

538 CYNWOOD DRIVE
SUITE 2
EASTON, MARYLAND 21601
Telephone: (410) 763-8999
Fax: (410) 763-6949

Insurance/Medicare Authorization

I the undersigned certify that I (or my dependent) have the insurance coverage as presented to the medical office today and assign directly to Bayside Family Practice, L.L.C. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I am responsible for all charges if I do not have insurance or the service provided is not a covered service. I authorize the office to balance bill me by credit card on file or bill me for any services not covered by my insurance company, if I have one. I agree to pay all reasonable attorney fees and collections costs in the event of default of payment of my charges. I hereby authorize the doctor to release all information necessary to secure the payment of benefits, including by fax or electronic transmittal. I authorize the use of this signature on all insurance submissions.

If I have now or in the future receive Medicare benefits then I request that payment of authorized Medicare benefits be made to Bayside Family Practice, L.L.C. for any services furnished me by that medical office. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If %other health insurance+is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier

Signature: ____ Date: __________________

Patient Consent Form

By signing this form, you are granting consent to Bayside Family Practice, L.L.C. to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our ***Notice of Privacy Practices*** provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our ***Notice of Privacy Practices*** before you sign this consent.

Our ***Notice of Privacy Practices*** is subject to change. If we change our notice, you may obtain a copy of the revised notice by: contacting Bayside Family Practice, L.L.C. at 410-763-8999 or 538 Cynwood Drive, Suite 2, Easton, MD 21601.

You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

Signature: ____ Date: ____________________

Print Name: ____ Date of Birth: _____________

Patient Name (if different): ____