**Dr. Peter Guhl, PLC & Associates**
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## PART 1 CONSENT TO USE OR DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HELATH CARE OPERATIONS

In the course of providing service to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct health care operations involving our office.

We have a comprehensive Notice of Privacy Practices that describes these uses and disclosures in detail. You are free to refer to this Notice at any time before you sign this consent document. As described in our Notice of Privacy Practices, the use and disclosure of your health information or treatment purposes not only includes care and services provided here, but also disclosure of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment, our submission of your health information to auditors hired by third-party payers and insurers, among other aspects of payment described in our Notice of Privacy Practices. Our Notice of Privacy Practices will be updated whenever our privacy practices change. You can get an updated copy here at the office or from our Web site.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services, and to perform health care operations. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services, or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent. We can decline to serve you if you elect not to sign this consent form. You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or health care operations, but as directed in our Notice of Privacy Practices, we are not obligated to agree to these suggested restrictions. If we do agree, however, the restrictions are binding by us. Our Notice of Privacy Practices describes how to ask for a restriction.

## Part 2 INSURANCE BILLING DISCLOSURE AND AGREEMENT

You, the patient, or on behalf of the patient, will allow us to release information to your insurance company for the purposes of obtaining payment on your behalf.

Any primary care referrals, prior authorization numbers, or other approvals required by your insurance carrier are the responsibility of the patient or the guardian of the patient to obtain. This includes any that are needed for either the initial examination or for any additional services or tests that need to be performed. If the patient or patient's guardian fails to obtain the proper authorization prior to having services rendered by Dr. Peter Guhl, PLC & Associates, then the full cost of treatment becomes the responsibility of the party whose name is listed below.

All costs of treatment performed are the patient's or guardian's ultimate responsibility. If we accept assignment of your claim for payment, we are responsible for submitting one claim form that reflects the services and materials that were obtained from us. After the insurance company responses, appropriate adjustments may be made to the account per any specifically contracted agreements with your insurance company on assigned claims. If your claim is denied or charges are outstanding on the patient's account after we have adjusted your account then the patient or guardian agrees to promptly pay the balance on the account.

The patient or guardian is responsible for exam appointments not kept as scheduled and will be charge a fee for missed appointments, or for services declined due to lack of insurance coverage, when they are not cancelled at least 24 hours in advance. These fees are not billable to your insurance company. We reserve the right to assess finance charges and to pursue collection of any debt in arrears including adding an additional 33% of the outstanding balance as a collection fee and any other costs as deemed necessary.

I understand what my insurance benefits are and hereby choose to go forward with treatment as deemed reasonable and necessary by Dr. Guhl and agree to be responsible for charges that the insurance company does not cover.

**I HAVE READ THIS DISCLOSURE AND CONSENT AND UNDERSTAND IT. I CONSENT TO THE USE AND DISCLOSURE OF MY HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS. I HAVE READ THE ABOVE AND AGREE TO THE TERMS SET FORTH.**

Patients Name: _____ Patients DOB: _____

Responsible Party's Name: _____ Date: _____

Responsible Party's Signature: _____ Account Number: _____

Witness: _____ Source of Authority: _____