

INITIAL ONE:

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MEDICARE B SIGNATURE AUTHORIZATION: I authorize MIMA to release to the Social Security Administration and Centers for Medicare & Medicaid Services, its intermediaries, carriers, or billing agents and any secondary insurance, any information needed for related Medicare claim(s). I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment.

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INSURANCE AUTHORIZATION: I authorize MIMA to submit a claim(s) to my primary and secondary insurance carriers, on my behalf, for physician and/or ancillary services. When requested by my insurance company, I authorize MIMA to release all related health care information needed to pay the claim. A photocopy of this authorization may be used in lieu of the original.

NOTICE OF HEALTHCARE INFORMATION: All patient records remain the property of MIMA. Patient Records may be accessed by any MIMA medical provider, or MIMA employee, as a necessary function of their role within our organization. MIMA does not release Patient Records unless necessary for treatment, payment or operations, or when a valid Health Information Release Form has been signed authorizing release or transfer of records. Any non-MIMA records that are included in the MIMA chart will be considered a permanent part of the patient record. At this time, MIMA does not use e-mail as an official means of healthcare communication. MIMA offers (PAL), Patient Access Link as a secure means of communicating with the physician offices regarding healthcare needs. In accordance with Federal and State Law MIMA is required to share certain healthcare information with Tumor Registry, Tumor Board, Department of Health and Human Services and the Center for Disease Control (CDC). MIMA has a close working relationship with local hospitals, rehabilitation centers, Hospice, pharmacies, nursing homes and home health care agencies. In an effort to facilitate safe medical care, it may be necessary that MIMA obtain information from or grant access to your medical record to any of these facilities or agencies directly involved in your care. Following all Federal and State Security Regulations and Recommendations, MIMA retains the right to develop, maintain and support a Personal Health Record (PHR) for MIMA patients.

RESEARCH: There are a number of research studies conducted by MIMA physicians at any given time. Clinical research studies, (also called medical research or clinical trials), are done to determine the effectiveness of new drugs in order to improve treatment or prevent disease, and to assess their safety. MIMA physicians may or may not be compensated to participate in such clinical research protocols. Any patient may be identified as a potential research participant based on a drug regime or diagnosis. The decision to become involved in a research protocol is strictly voluntary and will not affect my treatment as a patient at MIMA.

MIMA respects the rights of patient confidentiality and complies with all HIPAA and other federal privacy regulations. A notice of MIMA privacy policies is available upon request. I acknowledge, by signature below, that I have been made aware of my right to review or obtain a copy of the policies.

AUTHORIZATION FOR ROUTINE ANCILLARY SERVICES AND MEDICAL TREATMENT: The undersigned consents to medical treatment and minor surgical care, as may be deemed necessary or advisable in the judgment of my physicians or other MIMA providers. Such medical and surgical care and treatment may be performed at any MIMA facility, including emergency treatment or services, and may include, but not limited to, lab procedures, x-ray examination, medical and surgical treatments or procedures, and medication administration including, but not limited to immunizations and injections. I allow my physician to dispose of as they see fit, any lab specimens taken from my body during clinical visits (i.e. the lab can dispose of a blood specimen after it has been processed).

I have been advised payment is due at time of service. I understand that I will receive itemized statements of my account reflecting the balance pending with insurance and due from me. It remains my responsibility for final payment on my account, regardless of the payment, or lack of payment by my insurance carrier. I accept these arrangements while continuing to receive care and services from Melbourne Internal Medicine Associates (MIMA).

This authorization and assignment is to be a continuing one, remaining in force until revoked in writing by the undersigned. I, the signee, agree to the above.

PATIENT NAME (PRINTED): _____ **DOB:** _____

PATIENT'S SIGNATURE (REQUIRED): _____ **DATE:** _____

Parent/Trustee/Guardian - if patient is a minor or unable to sign. By signing below I agree to pay if patient defaults.

NAME (PRINTED): _____ **RELATIONSHIP:** _____

LEGAL SIGNATURE (REQUIRED): _____ **DATE:** _____