The Oregon Clinic, PC (TOC)
Consents, Releases, and Agreements

Patient Name (please print)	***Date of Birth***

Notice of Uses and Disclosures of Protected Health Information

I acknowledge that I have been provided with TOC's Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that may occur in my treatment, payment of bills, or in the performance of health care operations of TOC, as well as my individual rights and the duties of TOC with respect to my protected health information.

I understand that The Oregon Clinic PC may use or disclose my protected health information to diagnose or provide treatment for me, to obtain payment for health care expenses, or to conduct health care operations. "Protected health information" includes information created, maintained, or received by TOC that identifies me, or from which my identity could be determined, and which relates to my past, present or future physical or mental health, condition, treatment, or payments for medical services.

TOC reserves the right to change the privacy practices that are described in its Notice of Privacy Practices. TOC will post any revised Notice of Privacy Practices in its office. In addition, I may obtain a revised Notice of Privacy Practices by contacting TOC and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Patient Signature	***Date***

Financial Agreement and Assignment of Benefits:

Medicare & Medicaid: I request that payment under the medical insurance program be made either to me or to The Oregon Clinic (TOC) on any bills for services furnished to me during the effective period of this authorization and I authorize the above named provider to release to the Social Security Administration or its intermediaries or carriers any information needed for this claim or any related Medicare claim.

All other Payors: I authorize payment directly to TOC of all benefits otherwise payable by any insurance policy(s) and I hereby irrevocably assign such benefits to TOC in an amount not to exceed the charges for services rendered.

I agree to be financially responsible for the balance left after processing by my insurance. If not covered by insurance, I agree to be financially responsible for services rendered. If I am unable to pay in full, I understand that a payment plan may be established.

Patient Signature	***Date***