CONNECTICUT BACK CENTER
Comprehensive Spinal Care

HIPPA Privacy Restrictions Questionnaire

Patient Name: _____ DOB: _____

May we send statements to your home?	☐ Yes	☐ No
May we leave messages (including test results) on your answering machine/voicemail?	☐ Yes	☐ No
May we send you a fax? Fax #:	☐ Yes	☐ No
May we contact you via email? Email Address:	☐ Yes	☐ No

Please list names and relationships of persons who we may release information or talk to about your care/appointments:

_____ _____

_____ _____

Consent for Treatment/Release of Medical Information

I consent to treatment necessary for the care of the patient listed above. I hereby authorize release of all medical records to the referring and family physicians.

Signature: _____ Date _____

For restrictions to your protected health information (PHI) other than noted above, please submit in writing to the compliance/privacy officer utilizing our “restriction of use or disclosure of protected health information” (PHI) form.

Financial Responsibility - Insurance Agreement

I acknowledge full responsibility for services rendered and agree to make definite financial arrangement for payment. I understand that the charges for professional services may not be covered fully by my insurance company and therefore, I am solely responsible for payment of all services. I authorize the release of any information necessary to determine liability or payment and to obtain reimbursement on any claims. I authorize that payment of medical benefits be made to Jesse G. Eisler, M.D. I assign the benefits payable to which I am entitled including government, private insurance and other health plans, to Jesse G. Eisler, M.D. This assignment will remain in effect until revoked by me in writing

Signature: _____ Date: _____