Authorization to Use or Disclose My Health Information
& Financial Responsibility Form

Patient Name: ______________________ Date of Birth: _______________________

I. My Authorization to the office of Dr. Christopher C. Peters at 540 East Jefferson Street, Suite 304, Iowa City, IA 52245.

You may use or disclose my health care information for insurance purposes, or to share information with primary or specialty physicians. Check one: Yes ____ No ____

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment,or enrollment). I may revoke this authorization by writing a letter to the office. I may not be able to revoke this authorization if its purpose was to obtain insurance. Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____________________________________ _____________________________________
Patient or legally authorized signature Date

_____________________________________ _____________________________________
Authorized name if signed on behalf of the patient Relationship to patient

I acknowledge that I have received the Notice of Privacy practices of Dr. Christopher C. Peters bearing the effective date of April 14, 2003. (See Hippa/Privacy Policy) I understand that the notice describes the uses and disclosure of my protected health information by the office of Dr. Peters and informs me of my rights with respect to my protected health information.

_____________________________________ _____________________________________
Patient or legally authorized signature Date

_____________________________________ _____________________________________
Authorized name if signed on behalf of the patient Relationship to patient

Financial Responsibility

If someone else is responsible for your bill, list that person here ______________________________
Address of responsible person ____
I will be paying today by: Cash ________ Check ________ C.C. _________

I also authorize payment of medical insurance benefits to the physician if he excepts assignment on claims for me.
Signature ____

I understand and agree that I am ultimately responsible for the balance on my account for any professional services rendered. I agree to be responsible for the costs of collection fees, or any type whatsoever, associated with the collection of any unpaid balance due and owing. This provision includes cost, fees, and other expenses incurred with any collection company or agency, or in a Court of Law, or otherwise. I have read all the information on the sheet and certify that my answers are true and correct. I will notify you of any changes in my health status or the above information.
Signature ____