



SUSAN E. JANOCIK, MD PLLC

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1. CONSENT FOR USE OR DISCLOSURE OF PATIENT INFORMATION FOR THE PURPOSES OF TREATMENT, PAYMENT, AND HEALTHCARE OPTIONS.

I hereby consent to Susan E. Janocik M.D., PLLC, using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for health care services rendered to me or to carry out the Practice's health care operations. I also consent to the Practice using or disclosing my protected health information for treatment activities provided by another health care provider, as well as the payment activities conducted by another health care provider or entity. I further consent to the disclosure of my protected health information in order for another provider or health care entity to conduct health care operations including quality assessment and reviewing the competence of health care professionals.

Specific Records Expressly Included. I expressly authorize release of the following information for the purposes of treatment, payment and health care operations, if it is a part of my protected health information: (check to include) chemical dependency/substance abuse (drugs and alcohol) and sexually transmitted diseases

I further acknowledge that Susan E. Janocik M.D., PLLC, has provided me a copy of its Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my protected health information.

Signature of Patient or Personal Representative _____ Date _____

Name of Patient or Personal Representative _____ Date _____

2. CONSENT TO RELEASE MEDICAL INFORMATION TO INDIVIDUAL PERSONS

I hereby give permission for medical information / test results to be released to the following person(s). If I wish to add to, remove from, or otherwise change the list below, I shall assume responsibility for notifying Susan E. Janocik, M.D., PLLC of the changes in writing.

Name _____ Relationship _____

Name _____ Relationship _____

Patient Signature _____ Date _____

3. CONSENT FOR MEDICARE AND PRIVATE INSURANCE MEDICAL INFORMATION RELEASE AND PAYMENT AUTHORIZATION

Medicare # _____ Name of beneficiary: _____

Check all that apply: hospital only medical office only both

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Susan E. Janocik M.D., PLLC for any services furnished me by the physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If Item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature _____ Date _____

4. CONSENT FOR ELECTRONIC COMMUNICATIONS AND GENERAL PRACTICE, PRIVACY, AND FINANCIAL POLICIES

Susan E. Janocik, MD PLLC (SEJMD) has provided me with its written financial, privacy, and general practice policies. I have read, understand and consent to the financial, privacy, and general practice policies of Susan E. Janocik, MD PLLC and I consent to allow SEJMD to send information about my medical care to me by way of (check all that apply): Home phone Cell phone U.S. Postal Mail Email (password protected) may leave message on voicemail or answering machine.

Patient Signature _____ Date _____