Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by Bay Area Endocrinology Associates LLC (BAEA, LLC) for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Bay Area Endocrinology Associates LLC. I understand that diagnosis or treatment of me by Bay Area Endocrinology Associates LLC may be conditioned upon my consent as evidenced by my signature on this document.

My "protected health information" means health information, including my demographics information, collected from me and created or received by physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is reasonable basis to believe the information may identify me.

I understand I have a right to review the Bay Area Endocrinology Associates LLC *Notice of Privacy Practices* prior to signing this document. The Bay Area Endocrinology Associates LLC Notice of Privacy could be provided to me. The *Notice of Privacy Practices* describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Bay Area Endocrinology Associates LLC. The *Notice of Privacy Practices* for Bay Area Endocrinology Associates is also provided at 5301 N. Habana Ave Ste. 1 Tampa, FL 33614. This *Notice of Privacy Practices* also describes my rights and the duties of Bay Area Endocrinology Associates LLC with respect to my protected health information. Bay Area Endocrinology Associates LLC reserves the right to change the privacy practices that are described in the *Notice of Privacy Practices.*

I may obtain a revised *Notice of Privacy Practices* by requesting in writing from Bay Area Endocrinology Associates LLC or asking for one at the time of my next appointment.

Financial Responsibility

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to Bay Area Endocrinology Associates LLC (BAEA, LLC) and or its affiliated entities for any charges not covered by healthcare benefits. It is responsibility to notify BAEA, LLC of any changes in my healthcare coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by BAEA, LLC and/or my healthcare insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form that I am accepting financial responsibility as explained above for all payment for medical services and/or supplies received.

Initials_____________

Assignment of Benefits

I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to Bay Area Endocrinology Associates LLC (BAEA, LLC) for all covered medical services and supplies provided to me during all courses of treatment and care provided by BAEA, LLC and/or its affiliated entities or otherwise at its direction. I understand and agree this Assignment of Benefits will constitute a continuing authorization, maintained on file with BAEA, LLC , which will authorized and allow for direct payment to BAEA, LLC of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by BAEA, LLC.

Acknowledgment of Receipt
Notice of Privacy Practices

I acknowledge that I can receive a copy of Bay Area Endocrinology Associates' Notice of Privacy Practices, which describes how BAEA, LLC will use and protect my health information. This Notice describes my rights under the ***Health Insurance Portability and Accountability Act*** (**HIPAA**) and Bay Area Endocrinology Associates' polices on use and disclosure of my protected health information.

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Name of Patient Name of Guardian or Personal Representative

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Signature of Patient Signature of Guardian or Personal Representative

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Date