CHART # ________________

DOCTOR________________

## LIFETIME AUTHORIZATION TO FILE MEDICARE

I request that payment of Medicare benefits be made to Kellett, Brophy & Lovell Neurosurgical Clinic for any services furnished to me by that provider. I authorize any holder of medical information about me release to the KBL and its agencies and information need to determine these benefits or the benefits payable for related services

Signature: ________________________________________ Date:________________________
Patient or Guardian

---

## CONSENT FOR CARE

I hereby give my consent for treatment to Kellett, Brophy & Lovell Neurosurgical Clinic including treatment or services and which may include but not limited to laboratory procedures, examination, medical treatment or procedures rendered for me under the general and specific instruction of the patient's physician.

Signature: ________________________________________ Date:________________________
Patient or Guardian

---

## AUTHORIZATION TO OBTAIN/RELEASE MEDICAL RECORDS

I authorize Kellett, Brophy & Lovell Neurosurgical Clinic or any person designated by them to obtain/release copies of my medical records to any physician or institution for the purpose of evaluation and/or comparison with examination and testing being performed on me.

Signature: ________________________________________ Date:________________________
Patient or Guardian

---

## AUTHORIZATION TO PAY BENEFIITS TO PHYSICIAN

I authorize payment to Kellett, Brophy & Lovell Neurosurgical Clinic for services rendered to me. I also authorize this office to release any information necessary to expedite insurance claims. I understand that I am responsible for any balance not covered by insurance and /or collection cost and legal fees incurred in any attempt to collect said balance. There will be a $ 25.00 charge for returned checks and $ 50.00 charge for appointments not cancelled 24 hours prior to appointment time.

Signature: ________________________________________ Date:________________________
Patient or Guardian

---

## AUTHORIZATION TO LEAVE MESSAGE

I hereby authorize Kellett, Brophy & Lovell Neurosurgical Clinic to leave a message reguarding pending appointments. You may notify me of lab/test results, matters relating to prescription, my physician or a Work Comp Carrier by leaving a message(check all that apply) on my answering machine/home voice mail with my spouse ______________, or family member(please specify name of family member)__________.

Signature: ________________________________________ Date:________________________
Patient or Guardian

---

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, outlining my rights regarding my health information.

Signature: ________________________________________ Date:________________________
Patient or Guardian

---