Oscar Castillo, DPM
820 LYDIG AVE.
BRONX, NY 10462
718-792-5900

ACKNOWLEDGMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy practices and that I have (or had the opportunity to read if I so chose) and understood the notice.

_____ _____
Patient name (please print) Date

_____
Parent or Authorized representative (if applicable)

_____
Signature

SIGNATURE ON FILE

- o I authorize the doctor named above to use my name on any and all claims documents that relate~~ to health insurance be~~nefits due to me and my dependents.
- o I authorize release of any information related to any claims to all my insurance companies or other relevant parties
- o I understand that I am responsible for my bill and agree to pay all charges for services and items provided to me
- o I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies
- o I authorize payment of health benefits otherwise payable to me, directly to my doctor
- o I permit copy of this authorization to be used in place of the original
- o This “Signature on File” is valid for one year from the date indicated below

_____ _____ _____
Signature of Patient, Guardian or personal representative Medicare # (if applicable) Date

_____ _____
Please print name of Patient, Guardian or personal representative Relationship to patient