Patient Authorizations & Acknowledgements

Release of Records

Name of Practice "Provider": Atwal Sleep & Wellness
501 S. Main St.
North Syracuse, NY 13212

I hereby authorize the release of any records from prior/current physicians or health care facilities to the Provider above. I also authorize the Provider to release records to any current physicians.

The term "records" above may include dental visits, medical visits, radiographs, and other tests. Records may be needed for coordinating care and more efficiently managing or treating your condition(s). Records may also be needed for insurance, follow up communication with your other health care providers for continuing care, or legal purposes. This authorization may be revoked by the person giving authorization by a written and dated notice, except to the extent that disclosure of information has been made prior to receipt of the revocation. I have read and understand this consent.

Prohibition of re-disclosure: This information has been disclosed to you from records, which are confidential. You are prohibited from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. A general authorization for the release of dental or other information is not sufficient for this purpose.

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Signature of Patient or Guardian

Patient Name: **Name of Guardian (if signed):**

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Date:

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Assignment of Benefits

Name of Practice "Provider": Atwal Sleep & Wellness
501 S. Main St.
North Syracuse, NY 13212

Assignment of Insurance Benefits

I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to Provider. I certify that the health insurance information that I provided to Provider is accurate. I authorize Provider to submit claims, on my and/or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to Provider. I also hereby instruct my benefit plan (or its administrator) to pay Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to Provider, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and Provider upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out the check to me and mail it directly to Provider. I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance.

Authorization to Release Information

I hereby authorize Provider to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims.

ERISA Authorization

I hereby designate, authorize, and convey to Provider to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan, as my Authorized Representative: (1) the right and ability to act on my behalf in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan? and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right to act on my behalf in respect to a benefit plan governed by the provisions of ERISA with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy.

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Signature of Patient or Guardian

Patient Name: **Name of Guardian (if signed):**

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Date:

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